PREFACE

Health Care Excel, Incorporated (HCE) is a private, not-for-profit corporation established for the purpose of providing clinically-based, objective, and independent monitoring of the quality, appropriateness, and medical necessity of health care services. Our goal is to improve health care processes and outcomes, as well as the health status of target populations. The mission of HCE is to promote the effective, efficient, and economical delivery of health care services of proper quality, and to make available professional resources and competence to evaluate, analyze, develop, and create information and data.

HCE, in its role as the Indiana Medical Policy and Review Services (IMPRS) contractor, is responsible for the Medical Policy (MP), Prior Authorization (PA), and Surveillance and Utilization Review (SUR) business functions. The MP Operations Procedures Manual has been developed to ensure the successful functioning of the MP department at HCE. The manual also may be used as a reference handbook for the Office of Medicaid Policy and Planning (OMPP), the PA and SUR departments, and other contractors and stakeholders.

As contrasted with other occurrences within the MP and Review Services contract, the formulation of, and support for, IHCP medical policies will involve an array of individuals and a complex set of tasks for each policy. The management of medical policy must involve the careful consideration of HCE's stakeholders-the State, the provider community, and the Indiana Health Coverage Programs (IHCP) member community, and be collaborative in nature to promote a positive, effective, and responsive approach to customer service. By its unique nature, it must strengthen the foundation of the IHCP, irrespective of the governing agency or health care delivery system.

Our objective is to ensure that the IMPRS contract is managed effectively, coordinated with other stakeholders (the State, the provider community, and the IHCP member community) and contractors, and provides excellent service to the State of Indiana. The IMPRS contract is subject to the oversight of the OMPP, Indiana Family and Social Services Administration (FSSA). FSSA is the umbrella agency responsible for administering Indiana's public assistance programs.

Proactive medical policy formulation requires constant and effective communication. HCE will conduct regular, structured communication with the State to anticipate and/or react to policy issues of interest to the Legislature and/or the State. We will be in communication with the medical community, both in Indiana and nationally, seeking to identify the issues that are most likely to arise as IHCP policy issues. We will listen to the opinions of others, and evaluate the impact of proposed solutions on patient needs and care, costs, and the stakeholders. We will communicate with the medical community through participation in provider association meetings, and listen to the problems, concerns, and potential opportunities presented by the State and IHCP members.

TABLE OF CONTENTS

I. OVERVIEW

A. Indiana Health Coverage Programs and Medical Policy Responsibilities for the IMPRS Contractor

The FSSA is the umbrella agency responsible for administering Indiana's public assistance programs. The oversight of the IMPRS contract has been delegated to the Director of Program Operations, OMPP.

HCE has responsibilities for the creation and maintenance of the MP Manual that will contain the medical policies subject to the Indiana Medicaid Medical Assistance Program. Therefore, its responsibilities for communication and coordination will extend beyond OMPP, but will work within the direction and processes established by OMPP in conducting the communication and coordination with other agencies, associations, and contractors.

Of importance to our duties is a competent comprehension of the Indiana Administrative Code (IAC), among other legal mandates and directives. The IAC contains the rules, as amended, on IHCP covered services. As an IHCP contractor, HCE must adhere exactly to any provision in the IAC that affects IHCP. The 405 IAC 5 sets forth the details on all IHCP covered services by rule number. Where the IAC is not explicit or is silent as it relates to medical necessity and/or reasonableness and quality of care, HCE has incorporated other tools, such as medical criteria, in its operations. The responsibilities to gather, organize, and maintain all relevant legal and non-legal criteria identified for use by HCE in its operations has been assigned to the MP department. The criteria procedure has been discussed in **Section III** of the MP Operations Procedures Manual.

We recognize the need to integrate and coordinate our three business functions of MP, PA, and SUR. Each business function complements the others. MP provides an important underpinning to the objectives of PA and SUR. The internal Operations Assessment Committee (OAC) will serve as an important mechanism to evaluate the overall responsiveness of the operations to achieve optimal performance through effective and timely communications and actions. The OAC is comprised of the senior management and Medical Director (MD) associated with the contract. Each department Director receives education and information on all business functions to facilitate cross-training objectives.

B. Objectives of Medical Policy

Medical policy provides consistent guidelines for State policy throughout the IHCP and interfaces with numerous other functions. The medical policy responsibilities require a global perspective, since the implications from medical policy are far reaching and have intended, and, perhaps, unintended consequences. Essential to the global perspective is collaboration and coordination among all interested parties. The primary coordination for policy rests among the IHCP business functions such as managed care, third party liability, PA, claims processing, and utilization activities to effect appropriate management of the program.

There are several objectives for the MP business function. The State's objective for the MP business function is to develop IHCP policy that is consistent with State and program objectives and that reflects current medical knowledge and practice. The State expects the MP contractor to take a lead role in providing research, analysis, implementation support, and management (including tracking and documentation) of Indiana's policies and cost-containment activities. HCE will take a proactive approach to the following activities.

- Assessing and modifying existing medical policy.
- Evaluating input from providers, members, and operational activities, and determining if there are policy implications, including consideration of who is impacted, what policy needs to be addressed, why the policy implication is important, when a policy should be changed or added, where the impact will be felt the most, and how to best address identified issues.
- Coordinating the resolution of issues that bridge operations and policy areas.
- Recommending new medical policy to address emerging issues.
- Determining and analyzing indicators to evaluate utilization of services, access, preventive care, quality of care, and disease management.

After policy implementation or revision, we will follow the changes that occurred and communicate to the State any perceived consequences, trends, or other information which may result in other medical policy projects. Actual change in service delivery or utilization will be compared to expected changes to measure policy effectiveness. Unexpected consequences and achievements will be measured and discussed with the MP contractor staff as part of the quality improvement cycle.

HCE's definition of the customer and customer service has been stated in terms of our goals to serve the needs of the three primary stakeholders-the State, the provider community, and the IHCP members-from their perspective and not ours. Our medical policy operations will assist in assuring that the State meets the needs of the IHCP members, complies with State and Federal mandates, and maintains the fiscal integrity of the program. For the provider community, our intent is to meet expectations in terms of scientific and sound medical policies; to conduct a timely and accountable PA program, a fair and correct utilization review; and to take appropriate action to minimize fraud, abuse, and waste.

For the IHCP member community, meeting its needs means carrying out the three business functions so that receipt of medical services and supplies is not bureaucratically impaired nor adversely affected more than is minimally necessary to carry out the IMPRS contract. The IHCP members shall be served with seamless, quality services delivered through HCE, in partnership with others serving the IHCP.

Success will be achieved only when we have instilled the desire and supported the ability of each employee to continually think of the customer and how they can best serve the customer through their daily duties and work products. Serving the customer is more than the achievement of numerical goals, although the numbers are indicators of performance. Needs must be met and expectations fulfilled.

The methodology for ensuring that staff is delivering customer service will be through the establishment of monitoring protocols within the IMPRS daily operations, and information gleaned from many sources, including satisfaction surveys. For example, surveys conducted by Electronic Data Services (EDS) (or others) will elicit opinions from any or all of the stakeholder groups. Focus groups are another technique to determine issues and levels of program satisfaction. Internal monitoring spans a broad array of duties and will form the foundation for assessing customer satisfaction as follows.

1. State satisfaction can be assessed through feedback on contractor performance.

2. Provider satisfaction can be assessed through responsiveness to providers' issues and concerns, usefulness of written program materials and provider meetings, and the responsiveness and clarity of medical policy.

3. Member satisfaction can be assessed through feedback from surveys, complaints, and inquiries from external sources.

Customer service is not the responsibility of one individual or department, but is the result of all design, production, and management activities. HCE provides the highest level of customer service at all levels and all points of contact with the customers.

Figure I-1 contains a few examples of our activities to serve the stakeholders.

Figure I-1

MP Activities	Stakeholders		
	State	**Providers**	**Members**
Develop and maintain medical policy requirements	Consistent medical policy provides the State with a manageable program	Clear medical policy helps the providers comply with program requirements	Clearly stated medical policy makes the program understandable and less bureaucratic
Medical policy research	Finds solutions to perplexing policy issues	Identifies and eliminates provider stumbling blocks	Identifies problems before they impact members
Implementation Support	Clear descriptions of policies and expected impacts help the State explain policies to interested parties	Proper education prior to policy implementation aids providers with transition	Special populations are served by having possible adverse impacts detected prior to implementation

C. Medicaid Management Information System (MMIS) and Systems Support for MP

The MP business function uses a variety of Indiana*AIM* systems functions including:

- ♦ information from the provider tables;
- ♦ information from the member tables;
- ♦ information from the reference tables;
- ♦ information from the SUR and MARS Report Menus; and/or
- ♦ ad hoc reporting capabilities.

D. Medical Policy Department

The Program Director (PD) for the IMPRS contract oversees the Medical Policy Director (MPD). The MPD will work closely with the PD, the MD, the Director of PA, and the Director of SUR to internally coordinate activities at HCE to achieve the objectives of the three business functions. Management staff will participate in weekly OAC meetings to discuss issues of mutual interest, formulate actions, and evaluate action plans. This internal quality assurance and improvement function will promote fulfillment of contract responsibilities and responsiveness to the stakeholders. An overview of the MP department staffing and responsibilities has been presented in **Section II** of this manual.

There are several components that are shared among the MP, PA, and SUR departments. A few of these shared responsibilities have been listed below.

Shared Department Responsibilities

- Coordinate on State issues through the PD
- Coordinate on EDS issues
- Coordinate on relevant Indiana*AIM* and any subsystems issues
- Provide drafts of texts in a recommended format for printing and distribution of bulletins, banners, provider newsletter articles, and manuals by EDS
- Collaborate on the creation and maintenance of program
- manuals assigned to the MP contractor
- Collaborate on the creation and maintenance of program
- plans assigned to the MP contractor
- Participate in program meetings and coordinate actions
- Maintain optimal staffing and competency levels
- Participate in achieving the Quality Management objectives
- Participate in achieving the Customer Service and Annual Business Plan objectives
- Participate in fraud detection and prevention activities
- Participate in the evaluation and impact of changing medical practices
- Contribute to and maintain the complaint tracking and reporting system
- Adhere to all data and record retention policies
- Adhere to documentation standards

E. Privacy Plan

- All employees, consultants, and reviewers are subject to confidentiality standards and guidelines at HCE. Implementation of the Privacy Act under the Health Insurance Portability and Accountability Act (HIPAA) adds to the confidentiality requirements necessary for the MP department. Under the provisions of covered entities, the MP department is an extension to the IHCP and must adhere to the additional requirements of the Privacy Act.

- The MP department frequently handles and accesses confidential and protected health information material. The MP department implements several measures which in combination provide for the security of the confidential material. (Additional security and confidentiality is outlined in the Facilities and Security Plan.)

- All employees, consultants, and reviewers are subject to the provisions of the Privacy Policy and Procedures Manual. After receiving education in privacy, each employee must sign a statement or form indicating his or her understanding and compliance with the plan.

- The departmental entrances are labeled with restricted access. No unauthorized person is permitted beyond the restricted access areas without supervision from a HCE employee. All visitors and/or guests are required to sign-in on an attendance roster located in the reception area. All visitors and guests must be accompanied by an authorized HCE employee at all times when in the restricted areas.

- All employees must have a name badge visible to identify themselves as HCE employees.

- The MP department accesses and maintains confidential material. User names and passwords are required to access this material. No employee is permitted to share his or her user name or password with anyone else. Unattended computer terminals are to be secured from unauthorized access into the system.

- The MP department frequently maintains and handles confidential paperwork that can include faxes and copies of protected health information. All confidential material is maintained within the restricted or secured areas of HCE. Confidential material must always be concealed from plain view. Confidential bins are available in each department for disposal and shredding of confidential paperwork and material. All confidential material should be placed in these labeled bins for proper disposal of protected health information. At no time should protected health information or confidential material be disposed of in regular trash bins.

- All breaches of confidentiality are to be reported to the MPD, the PD, or alternative Director. Additional information regarding confidentiality and security is outlined in the Facilities and Security Plan, Quality Management Plan, and the Handbook for Peer Reviewers and Consultants.

F. Consultants and Advisory Panels

Periodically there will be a need to involve health care associations, physicians, and other health care practitioners in the medical policy processes. The MD will support the medical policy objectives through the establishment and building of relationships with the medical community. The participation of the medical community will be in an advisory role to the MP contractor.

The MD of HCE will make the determination that there is an internal need for an advisory panel and request approval from OMPP to form a panel to consider the medical policy issue. If OMPP grants the request for an advisory panel, the MD will coordinate and direct the event.

HCE will create, manage, and participate on advisory panels composed of members of the provider community. Advisory panels will be used to gather information, share opinions, and discuss medical policy issues in relation to current trend analysis, development of new medical policies, evaluation of current medical policy, and associated activities. A roster of medical policy consultants and associations, which could potentially serve in an advisory capacity to the MP contractor, will be maintained through the office of the MD for HCE.

The MPD and MD will work with the State to confirm the State's expectations and requirements for panels and identify potential panel members. A representative from EDS, as the Fiscal Contractor, also may be designated to attend advisory panel meetings.

G. Companion Manuals and Plans

There are a broad array of manuals and plans that should be used in conjunction with the medical policy operations procedures, a few of which have been listed below. The list is not intended to be all-inclusive. The content of these manuals has not been duplicated in the MP Operations Procedures Manual. **(Refer to Exhibit I-1.)**

- Customer Service and Annual Business Plan
- EDS operations procedures manuals and plans
- Facilities and Security Plan
- Hoosier Healthwise Managed Care program manuals
- IHCP plans, manuals, and reports
- Indiana*AIM* manuals
- Medical Criteria
- Medical Policy Manual
- PA Operations Procedures Manual
- Privacy Policy and Procedure Manual
- Quality Management Plan
- Restricted Card Program Operations Manual
- SUR Operations Procedures Manual
- Turnover Plan

The MP department may also use information in Indiana law, Federal laws, HCE corporate policy manuals, and correspondence to the provider community from the State.

EXHIBIT I-1

1. **Customer Service and Annual Business Plan**-An interactive and flexible working document that details business improvement objectives for the upcoming year and the methodology for performing activities and meeting objectives. This plan also includes information about requirements and processes for maintaining and improving customer service.

2. **EDS Operations Procedures, Manuals, and Plans**-Manuals, procedures, and plans containing information about work plans, transition, scheduling, database system, transfer and testing, operations and business activities, quality management and customer service.

3. **Facilities and Security Plan**-A plan containing information about the physical components of the working environment, including location of the facilities, conference rooms, State office requirements, fax machines, copiers, telephone systems, electronic mail, data network and connections, employee safety, and workflow information. This plan also includes both the physical (building(s)) and database security procedures, including any off-site or storage facilities, physical access, and database access (both network and Indiana*AIM).* This plan includes procedures regarding visitors and vendor access in order to promote confidentiality of information, and procedures for recovery of business operation functions in the event of a catastrophe.

4. **Hoosier Healthwise Managed Care Program Manuals**-Manuals containing information about the organization of the Hoosier Healthwise Managed Care Program, coverage and eligibility of program members and the provisions, program, personnel administration, and financial administration.

5. **Indiana*AIM* Manuals**-Manuals which explain the use of the Indiana Advanced Information Management System, a computer database used to process and adjudicate IHCP Claims.

6. **Indiana Health Coverage Programs plans, manuals, and reports**-Manuals and plans containing information about the organization of OMPP, coverage and eligibility of program members, general provisions, general program, personnel administration, and financial administration.

7. **Medical Criteria**-Screening guidelines, approved by the State and formulated through the input of expert consultants and research of current literature.

8. **Medical Policy Manual**-A manual containing medical policies for the IHCP. The manual has information about covered services and limitations related to the services.

9. **PA Operations Procedures Manual**-A manual that contains information about the organizational structure, staffing and responsibilities of the PA department. It includes procedures, reporting information, sample forms and letters, and quality management information.

10. **Privacy Policy and Procedure Manual**-A manual that contains information about the IMPRS policies concerning how to safeguard the privacy of protected health information under HIPAA.

11. **Quality Management Plan**-A plan with information about training and remedial training of staff, education for consultants and advisory panels, and performance measurement tracking and procedures, and reporting in relation to quality of service. It includes training of employees in general office functions and in more specific functions relating to the individual job responsibilities within the organization.

12. **Restricted Card Program Operations Manual**-A manual that contains information about the organizational structure, staffing, and responsibilities of the Restricted Card Program. The manual contains step by step procedures for implementing restriction of an IHCP member's eligibility, maintaining the restriction, and reporting responsibilities.

13. **SUR Operations Procedures Manual**-A manual that contains information about the organizational structure, staffing and responsibilities of the SUR department. It includes the review procedures, reports, sample forms and letters, and quality management information.

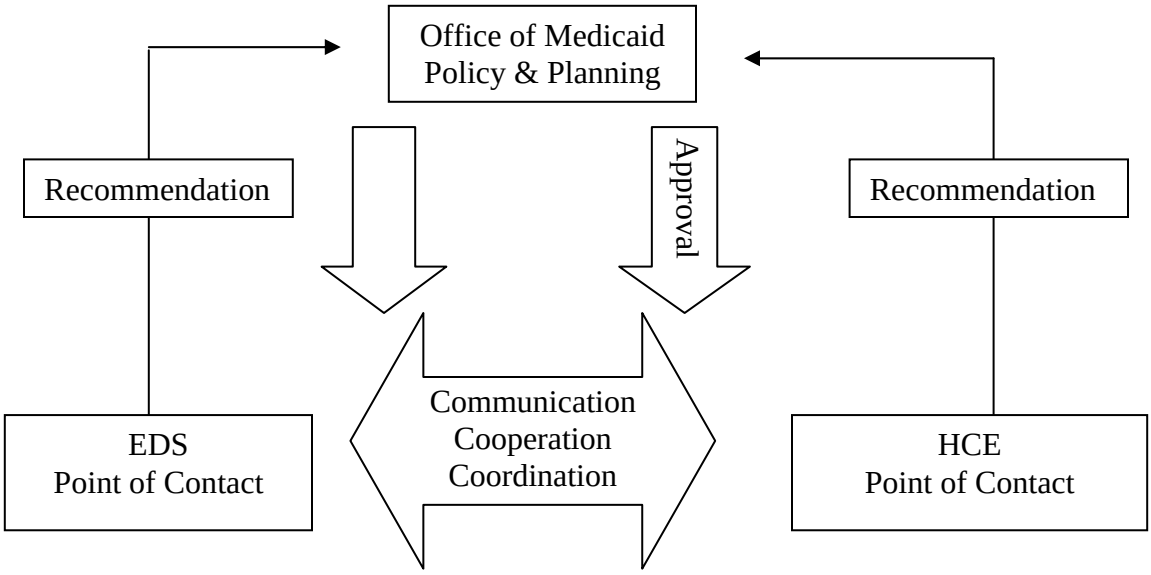
14. **Turnover Plan**-A plan containing information to ensure that the new contractor and/or the State obtains all of the reference documents, database material, reports, and manuals from the previous contractor, so that customer service is not interrupted or delayed.

II. ORGANIZATIONAL STRUCTURE, STAFFING, AND RESPONSIBILITIES

The MP department will coordinate activities with the other operations departments at HCE—PA and SUR—with EDS and other IHCP contractors, and the State. There will be regular meetings to establish and monitor goals and objectives, evaluate processes, and to work together to effect improvements in the program. The figure below represents the flow of information among EDS, HCE, and the State, the principal partners in this process.

Figure II-1

COMMUNICATION, COOPERATION, AND COORDINATION



A. Organizational Structure and Medical Policy Staff

The MP department has been staffed to ensure the fulfillment of its functions and to provide optimal customer service to the State, providers, and IHCP members. The MP staff consists of a Director, Statistician, Specialists, and support staff. (**Refer to Exhibit II-1**.) All staff must achieve and maintain performance standards, and meet or exceed the position qualifications established by the State and HCE. The Quality Management Plan delineates internal monitoring processes and performance standards.

The Quality Management Plan provides the framework for initial and continuing education. Of particular importance is the need for continuing

education on the appropriate health care and delivery systems that support the objectives of the IHCP. Another area of importance is a competent functional understanding of the relevant aspects of Indiana*AIM*, which is a common bond among all stakeholders and contractors. The PD will provide ongoing support to help identify and address the need for staff education.

The management of the MP department is the responsibility of the MPD. The MPD is responsible for optimal functioning of the department to ensure that the department achieves the objectives established in the contract on behalf of the IHCP. As the result of approved new or changed medical policy, the MPD is responsible for tracking the changes communicated to EDS that are associated with Indiana*AIM* and subsequent monitoring to ensure that all changes have occurred at HCE and EDS. The MPD is responsible for MP Committee meeting preparation. The MPD serves as a member of the Operations Assessment Committee. The MPD has been delegated the responsibility for managing the production of the MP department and routinely reports achievements, areas of concerns, and recommendations to the PD.

The **Medical Policy Specialists (MPS)** conduct the duties associated with research and analysis to support medical policy activities, creation of fiscal impact statements, formulation of recommendations, and preparation of reports and other medical policy documents. The Specialists maintain the medical policy project files assigned to each of them. The majority of written draft documentation related to specific medical policies will be the responsibility of the MPS.

One MPS has been assigned the responsibility for ensuring that the MP Manual has been updated on a routine basis. MPS are assigned the responsibility of assuring that the staff disseminates only high-quality written materials. MPS assist in creating and maintaining department documents and manuals in an organized, thorough, and accurate manner. MPS provide monitoring to ensure that documents related to medical policies are in accordance with the Indiana Administrative Code (IAC), and other legal mandates and directives.

MPS may attend relevant meetings of the MP Committee, according to the planned agenda. Presentations of the assigned projects will be an important role of the MPS. The MPS report to the MPD on progress and areas of concern.

The Statistician performs statistical analysis of data and the development of fiscal impact statements to support medical policy issues. The Statistician assists staff in the methodological design, development, and implementation of analyses of focused pattern of care studies and other quality improvement activities. The Statistician assists with the generation of reports, formulation of databases, and timely tracking of information. The Statistician reports to the MPD on progress and areas of concern.

The MP support staff is responsible for many duties including organizing files, assisting with written reports, maintaining operation calendars and tickler systems, scheduling meetings and arranging for any special equipment or materials to support the meetings, operating department equipment, and performing other assigned responsibilities.

The MP department staff is directly supported by other employees, the MD, and PD. The MD has a close working relationship with the MP department in support of the advisory panels, criteria, and medical policy management.

B. Additional Responsibilities of the MP Department

Exhibit II-2 depicts the general requirements assigned by the State to the MP business function.

Criteria development is a responsibility assigned to the MP department. The criteria include legal and non-legal documents. The PA and SUR departments will use the criteria developed and may assist in the development and initiation of criteria, but the responsibility for criteria development and maintenance has been assigned to the MP department. The MPD will be responsible for the management of the internal Criteria Workgroup that will meet on an as-needed basis. The committee will address criteria issues brought to it from other areas of the operations, and the MD will be involved in the meetings. Criteria will be discussed in **Section III** of this manual.

C. Coordination with EDS

EDS holds the contracts for the Claims Processing, Related Services, and Third-Party Liability. HCE has fundamental coordination responsibilities with EDS.

Overview of Coordination Activities

1. Coordinate new policy implementation or policy changes with the State, the Fiscal Contractor, rate-setting contractor, pharmacy benefit manager, providers, members, and other contractors, including the Managed Care Organizations, as specified by the State.

2. On an ongoing basis, assist Fiscal Contractor with the validation of the Reference file to ensure accuracy.

3. Interface with Fiscal Contractor to communicate new or changed medical policy that may impact billing procedures.

4. Prepare bulletins and coordinate issuance with the Fiscal Contractor.

5. Interface with Fiscal Contractor to revise edit and audit criteria, as appropriate, to reduce claims suspension rates and to ensure proper functioning in accordance with medical policy.

6. Provide, at a minimum, one (1) staff person to attend all managed care meetings.

7. Provide MP staff to attend provider association meetings when medical policy issues are on the agenda.

EXHIBIT II-1

MEDICAL POLICY DEPARTMENT
ORGANIZATION CHART

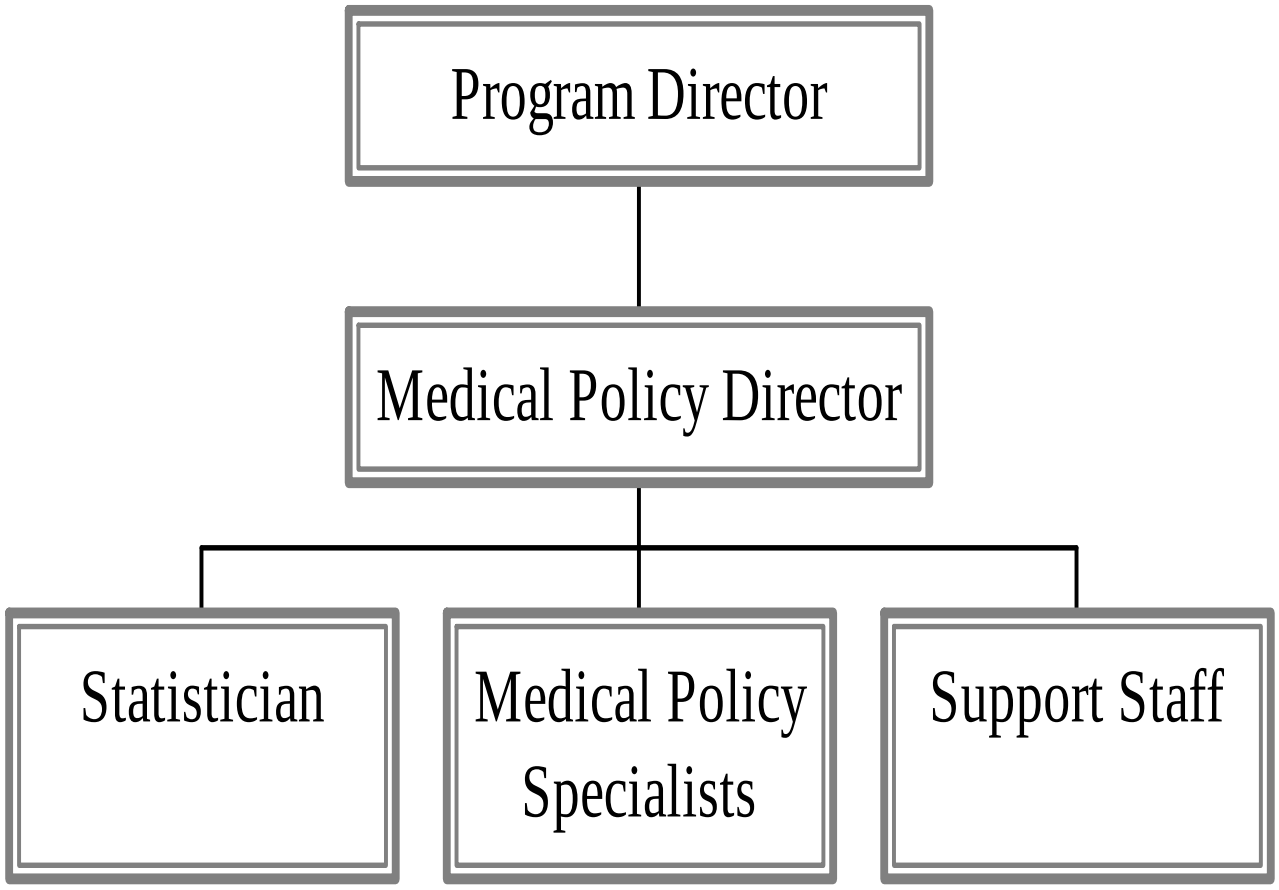


EXHIBIT II-2

MEDICAL POLICY OPERATIONS

General Requirements

1. Maintain staff familiarity with the IHCP policies and all State and Federal laws and citations relevant to the administration of IHCP.

2. Establish and maintain a subscription to applicable Indiana and Federal Registers, as well as other applicable references (e.g., Indiana Code), to ensure the Contractor has the most current information on new and forthcoming regulations and maintains awareness of newly developed procedures, in order to make recommendations regarding necessary changes to enhance program effectiveness. Distribute information on program changes to appropriate personnel.

3. Maintain membership in appropriate organizations to keep apprised of trends in the health care arena on a nationwide and statewide basis. Awareness of emerging technologies and trends must be maintained in order to proactively advise OMPP on recommended changes or additions to IHCP policy.

4. Maintain staff familiarity with Medicare medical policies and coverage issues. The Contractor must have and use staff who is very knowledgeable about the Medicare program and major third party payors.

5. Establish and maintain relations with Indiana's local Medicare carrier by appointing a liaison to facilitate communications with the Medicare carrier .

6. Provide sufficient staff to adequately research and make recommendations in a timely manner as specified by the State.

7. Provide knowledgeable medical policy staff to attend meetings on behalf of the State and with other contractors, as necessary.

8. On a monthly basis, submit, update, and maintain a work plan that delineates special projects, as well as ongoing activities. The work plan shall include expectations for the project timelines and the resources that will be dedicated to the project. The work plan will be subject to State approval.

9. Manage, define, and plan all MP project activities to ensure timelines are established, progress is tracked and reported to the State, and quality control checks are implemented to achieve optimal effective project results.

10. Complete requests for research from the State within three (3) days of receipt of the request or as specified by the State.

EXHIBIT II-2 (Continued)

MEDICAL POLICY OPERATIONS

General Requirements (Continued)

11. Develop an Annual Business Plan as specified in section 2 of the RFP.

12. Provide interpretations or clarification of Indiana medical policies as needed for applications to system updates, provider relations activities, or other IHCP business functions. Medical policy must be in accordance with, and consistent with, the scope, benefits, exclusions, and limitations of the IHCP program as specified in the current, promulgated Indiana Medicaid Covered Services and Limitations Rule, the Indiana Medicaid State Plan, and other state/federal rules and statutes.

13. Analyze current medical policies, research alternatives, and draft policies by issue. Develop and prioritize suggestions and recommendations, including the rationale, for changes to medical policies for State consideration.

14. Perform timely review of procedure and diagnostic code updates, make recommendations for coverage, PA, changes to edits and audits, service limitations and coordinate with the Fiscal Contractor to make the necessary changes to Indiana*AIM* and related business functions as a result of these updates.

15. Research all questions and/or issues from providers by 1) analyzing current medical policy in relation to current issues, 2) researching community standards or issues, 3) researching related or Academy positions related to the question or issue, and 4) researching Medicare standards and/or requirements. Send documented, cited responses to OMPP for approval.

16. Create, manage, and participate on advisory panels composed of members of the provider community. Advisory panels will be used in gathering information, sharing opinions, and discussing medical policy issues in relation to current trend analysis, developing new medical policies, evaluating current medical policies and defining quality-of-care parameters based on community standards of practice. The advisory panel shall provide input into the MP Committee meetings. The Contractor shall notify the State of meeting dates and provide information regarding the topic of the meeting, enabling the State to send appropriate representatives, as needed, to attend the meetings.

17. Manage and participate in the MP Committee meetings. Committee meetings shall occur periodic basis according to a schedule approved by OMPP and shall include members of the State advisory panel and other Contractors, including the Managed Care Organizations as necessary. The Contractor shall manage, define, plan and conduct the activities for the MP Committee.

EXHIBIT II-2 (Continued)

MEDICAL POLICY OPERATIONS

General Requirements (Continued)

18. Prepare drafts of rules and regulations, as well as fiscal impact statements, summary of public comments, and other internal documentation regarding medical policies for promulgation by FSSA. Provide assistance during the promulgation process, when requested by the State.

19. Prepare draft meeting agendas and submit them to the State for approval 10 business days prior to the scheduled meeting. Make State-suggested changes and distributes finalized agendas to participants prior to the meeting.

20. Provide draft meeting minutes to the State (e.g., Advisory Council meetings, MP Committee meetings, etc.). The State shall have the option to review draft minutes and make necessary corrections. Final minutes shall be distributed 10 days prior to the next meeting, or as specified by the State.

21. Maintain, provide timely updates to the current MP manual, and distribute all updates to appropriate State staff. At a minimum, the manual shall include:

    - ♦ New or changed medical policy guidelines (including TPL, SUR, and managed care policies)
    - ♦ New of changed medical criteria used to support PA, claims edits and audits, and the IHCP Program
    - ♦ New or changed benefit interpretations
    - ♦ billing procedures
    - ♦ New or changed policy statements, background, and statutory/rule citations
    - ♦ New or changed criteria supporting PA, SUR, payments, etc.

22. Update the MP Manual and any related manuals, at a minimum, on a quarterly basis. Submit the updates for State review and approval. Updates shall be distributed to the appropriate parties within 10 business days of approval by the State.

23. Submit proposed additions, changes, and deletions to the State for review and approval before incorporation into the manual.

EXHIBIT II-2 (Continued)

MEDICAL POLICY OPERATIONS

General Requirements (Continued)

24. Maintain an electronic copy of the MP Manual, and load the electronic document format to an electronic bulletin board, Web page, or other media deemed appropriate by the State. Provide the electronic copy in a format required by the State.

25. Ensure that all State-approved procedures and guidelines for the detailed administration of medical policies are met.

26. Proactively develop and maintain reliable contacts in the various provider specialty areas to assist the Contractor to research issues relating to medical policy.

27. Research and analyze current medical policies, utilization, PA, claims submission, billing practices, and other information to identify and recommend quality and/or cost containment initiatives or focus areas, or to monitor the impact of recent policy changes to utilization, member access or expenditures.

28. On a semi-annual basis, provide the State with a report of ongoing trend analyses to identify potential impacts to the IHCP Program. Upon completion of the analyses, provide the State with findings and recommendations, and their rationale, for program modification. This report will be based on:

    - Input from other departments, other contractors, providers or associations or State staff; this information will include member access, utilization, and provision of care issues
    - MP contractor analysis of claims data related to program changes that have occurred in the previous six months
    - Other concerns that have been identified by the State.

29. Perform ongoing analysis to provide the State with a report that summarizes the Contractor's review of all medical policies and procedures to ensure consistency with generally accepted knowledge and practices of medicine and delivery of medical care in Indiana. The Contractor will include proposed recommendations and the rationale for any changes to medical policy.

30. Develop and maintain relationships with medical policy groups in other states, CMS, private insurers, and appropriate professional organizations.

EXHIBIT II-2 (Continued)

MEDICAL POLICY OPERATIONS

General Requirements (Continued)

31. Work with the Fiscal Contractor to develop and define edit/audit criteria to support new and revised medical policy and coding updates. The MP Contractor should offer ideas for appropriate changes to Indiana*AIM* audits or tables that would impact MP or operations or any changes to *AIM* windows that support the scope of operations in MP, PA, or SUR. Additionally, operational policy requires the MP contractor to review any table updates that impact MP. This is mostly tables that include such things as procedure code groups, diagnostic code groupings, changes to audits and edits, etc.

32. Research, analyze, and determine covered/non-covered status for IHCP services and codes corresponding to same. Forward the information to the Fiscal Contractor for entry into the system.

33. Develop, implement, and maintain State approved policies and/or criteria used to identify and analyze utilization (high need, overutilization, high cost diagnoses, recipients, and providers, etc.).

34. Review the following program aspects in order to determine whether program modifications are required:

    - ♦ member access
    - ♦ utilization
    - ♦ preventive care
    - ♦ quality of care

35. Provide a semi-annual report to the State to document findings from the reviews, and provide the State with recommendations for possible changes

36. Meet with State staff, on a basis determined by the State, regarding medical policy and cost containment issues and objectives. The Contractor shall be responsible for coordinating meeting schedules and distributing an agenda prior to each scheduled meeting and for distributing meeting minutes to all participants.

EXHIBIT II-2 (Continued)

MEDICAL POLICY OPERATIONS

General Requirements (Continued)

37. Provide monthly, written medical policy reports with source-supporting documentation to the State of activities, issues, trends, utilization analyses, and researched suggestions and recommendations regarding medical policy and cost containment rules, procedures, and focus areas. The reports shall be submitted to the State within five business days following the end of the month.

38. Review, prepare detailed implementation plans, and implement State and federally initiated policy changes, as requested and approved by the State.

39. Prepare detailed and comprehensive reports of analyses and recommendations for both State and Contractor originated issues and for all proposed policy changes. Such reports shall include:

    - A description of the issue, policy, or proposed policy change
    - An analysis of tangible and intangible impacts on claim volumes, expenditures, access and quality of care, and provider relations resulting from both current or proposed policies, interpretations, or applications
    - Necessary system, operational, or procedural changes and any anticipated costs
    - An analysis of necessary policy changes and wording, if appropriate

    These policy/issue analysis reports shall be provided within forty-five (45) calendar days of request by the State, or other timeframe as agreed to.

40. Conduct an ongoing review of all medical policies and procedures to ensure that they are consistent with generally accepted practices of medicine and delivery of medical care in Indiana.

41. Recognize that all medical policy and related edits, audits, and documentation are subject to State approval; will remain the unrestricted property of the State; and must be turned over to the State or its designee upon conclusion of the contract.

42. Provide criteria used by PA, SUR, and MP in an organized format and provide the criteria to requesting providers. The Contractor may charge the provider no more than the cost of copying and mailing the requested materials.

EXHIBIT II-2 (Continued)

MEDICAL POLICY OPERATIONS

General Requirements (Continued)

43. Provide appropriate staff, as necessary, to attend and participate in appeals, hearings and to provide testimony to support interpretations of program policies and operations.

44. Employ qualified individuals who, at a minimum, are experienced in the medical field and familiar with information systems and who possess excellent written and verbal communication skills.

45. Prepare accurate and thorough written responses, as directed by the State, to written medical policy inquiries. Inquiries from government officials require a response within three business days of receipt of the inquiry. Inquiries from all other sources shall be responded to within 10 business days of receipt. Requests for public records shall be responded to within the statutory time limit of the Indiana Public Records Act (IC 5-14-3 et seq.).

46. The Contractor shall provide staff to meet the following requirements:

- A MD with overall responsibility for all medical policy, review, and cost containment management, meeting all specified requirements
- A MPD, meeting all specified requirements
- A minimum of three (3) full-time MP Analysts with at least two (2) years of medical policy related professional experience
- A minimum of three (3) Research Analysts with at least two (2) years of professional experience in analysis or research in medical policy, utilization review, or cost containment areas
- Professional medical policy review consultants sufficient to perform all specified medical review activities, with specialized expertise in dental, psychiatric, pharmacy, durable medical equipment, and other specialties, as needed; consultants shall have relevant professional experience in medical review activities
- Additional medical policy staff, as needed, to meet the requirements of this section

III. MEDICAL POLICY DEPARTMENT PROCEDURES

HCE has established workflow procedures to ensure that the medical policy functions are performed in an efficient, thorough, accurate, and timely manner, and are responsive to the needs of the stakeholders--the State, providers, and IHCP members.

As contrasted with other occurrences within the IMPRS contract, formulation and support for IHCP medical policies will involve a wide array of individuals and a complex set of tasks unique to each policy. It is not a single case interaction between the reviewer and a provider or IHCP member. The approach to medical policy must involve consideration of all stakeholders, and be collaborative in intent to promote a positive, effective, and responsive outcome. By its unique nature, medical policy endeavors must support the entire foundation for the IHCP, irrespective of the governing department or health care delivery system.

Therefore, medical policy operations procedures have been created to be specific, yet flexible. There are an infinite number of variations possible during the formulation of decisions and actions to create, modify, or eliminate a medical policy. HCE will evaluate input from providers, members, and operational activities, to determine if there are policy implications. Consideration is given to who is impacted, what policy needs to be addressed, why the policy is important, how the policy should be changed or added, and how best to address identified issues. The medical policy operations procedures provide the framework to support the medical policy process on behalf of the Indiana Medicaid Medical Assistance program.

A. Project Procedures to Establish and Maintain Medical Policies

The identification of the need to create new policy or modify existing policies may emanate from a wide variety of sources, both internally and externally. Internally, the need may become known through medical review activity, literature research, project collaboration efforts, committee activity, and awareness of issues during discussions with a provider, input from other State contractors, and other sources. Internal referrals from the SUR department will be documented on the Internal Referral form. Internal referrals from the PA department will be sent via e-mail to the Medical Policy Director. Externally, the need may become known through acts of the Federal and/or State governments, needs assessments from the organizations and agencies associated with Hoosier Healthwise and other State waiver programs, provider, member, and consumer organizations, among other sources. External referrals will be documented on the MP Inquiry form.

Procedures to establish and maintain medical policies include projects, and inquiries. Projects involve the development and modification of medical

policies, or requests for specific information (such as cost or utilization analysis) from sources such as the State or provider organizations. Inquiries are requests for information from IHCP providers, Indiana Health Coverage Programs members, or provider organizations and do not generally require as much detailed research as projects.

All inquiries and projects will be logged in the electronic medical policy master log. Information within the log will be updated by the MP Specialist assigned to the inquiry or project at least monthly for content and accuracy. Paper documentation associated with the inquiries and projects will be stored in restricted areas or shredded.

1. Initiation of Actions for New or Modified Policies, or the Elimination of a Policy

Upon receipt of a request for a determination of coverage, the existing medical policies in process or completed will be evaluated for application to a new issue, modification of existing policy, or the elimination of a policy. The MPD will assign the file to an MPS to conduct the evaluation. The assignment will include the date assigned, Specialist, response date to the MPD, and instructions. Project assignments will be communicated to the designated MPS.

The designated MPS will serve as a system monitor for all pending assignments to support appropriate management oversight by the MPD. Effective communications between the MPD and the MPS will occur to facilitate active policy management. The MPD will update the department work plan for policies-in-process related to new policy, modified policy, or the elimination of policy.

New issues to be completed will be organized by priority according to preferences established by the State. The MPD is responsible for managing priorities based on information from the MP Committee's quarterly review of the project list. All new issues will be assigned a target completion date with milestones to completion associated with significant tasks to be accomplished. A work plan will include the outstanding new issues and the entries will be updated to reflect progress from the original entry date on the work plan. **(Refer to Table III-1 and the Project Procedures Flowchart.)**

TABLE III-1: PROJECTS PROCEDURE

No.	Description of Activity	Responsible Party
1	If a MP project request is received that may be potentially controversial, HCE will gather the following information according to the OMPP communication protocol for presentation to OMPP, in addition to completing Steps 2-15. All projects, controversial or not, will adhere to the steps in the procedure, as applicable. A. A clear description of the requested service(s), and the current IHCP coverage status of each. B. Pertinent and relevant clinical information, including that of a historical nature, regarding the patient's medical condition. C. Possible or suggested provider(s) of service(s), including IHCP enrollment status of same, and any other information relevant to the requested services that may impact on the eventual provider(s) of service(s). D. Applicable cost considerations. E. HCE's suggestion(s) regarding how best to proceed in responding to the request(s). F. Clear and specific questions from HCE regarding any direction HCE believes is required from OMPP regarding the matter. After OMPP has received all available information, OMPP will coordinate the matter internally and advise HCE of any follow-up action required.	MPD

TABLE III-1: **PROJECTS PROCEDURE**
(Continued)

No.	Description of Activity	Responsible Party
2	Upon receipt of a request for medical policy projects for which there is no current medical policy, the MP department shall begin a project. The department will notify the requesting source that a project has been initiated.	MPD
3	The project is assigned a code that reflects an internal tracking system (e.g., 1998-001-PA-093-DME) allowing the MP department to monitor the progress of the request throughout its life cycle. The code will enable the MP department to track dates, sources, numbers, and types of requests.	MPD
4	The project internal tracking code will be assigned using the format YYYY-DDD-XXX-SSS-CC. A. YYYY - represents the year of the request (e.g. 2004) B. DDD – represents the Julian date of request (e.g. 041) C. XXX – represents that the record is a project (e.g. PRJ) E. SSS – represents the assigned number of the MPS and the daily assignment number (e.g. 391) F. CC – represents the two digit code of the service category for the project (e.g. DN for Dental)	MPD
5	Monthly status update reports are provided to OMPP regarding the nature and status of all medical policy projects requests undergoing medical policy review.	MPD

TABLE III-1: **PROJECTS PROCEDURE**
(Continued)

No.	Description of Activity	Responsible Party
6	The medical policy project requests will be received by the MP department and reviewed by the MPD. Requests may come from internal or external sources, including, but not limited to the following. A. surveillance information; B. focused reviews; C. edits and audits; D. excess utilization; E. under utilization; F. members; G. providers; H. contractors; I. OMPP; or J. Other government officials.	MPD
7	The MPD will assign the project to a MPS. The Specialist will gather background information on the medical project request to determine if the service requested is currently covered. The MP department must check with the SUR and PA departments, EDS, and OMPP point of contact persons for the current practices on the medical policy project request when necessary.	MPD/MPS
8	The MP department must do a search of case law, statutory requirements, and regulatory requirements that may have an impact on the medical request.	MPS
9	The MP department will submit the background information to the MPD.	MPS
10	The MPD will coordinate the review to determine if the project is medically relevant and if further research and analysis is warranted. The MPD will return the recommendation to the Specialist.	MPD

TABLE III-1: **PROJECTS PROCEDURE**
(Continued)

No.	Description of Activity	Responsible Party
11	The MP department shall conduct research and analysis on the request to determine any of the following information if deemed appropriate and necessary. ♦ Prevalence ♦ Number of people affected ♦ Surveillance Utilization and Review (SUR) analysis ♦ PA analysis ♦ State statistics ♦ Indiana State Department of Health (ISDH) ♦ Family and Social Services Administration (FSSA) ♦ State Budget Agency ♦ Office of Attorney General (OAG) ♦ National statistics Center for Disease Control and Prevention (CDC) ♦ National Institutes of Health(NIH) ♦ Office of Inspector General (OIG) ♦ Office of Management and Budget (OMB) ♦ Indiana Client Eligibility System (ICES) ♦ Indiana*AIM* ♦ Audits and Edits ♦ Fiscal Impact ♦ State Budget Agency ♦ Center for Medicare and Medicaid Services (CMS) ♦ Department of Insurance (DOI) ♦ Clinical Practice Guidelines ♦ American Medical Association (AMA) ♦ National and State medical groups/societies ♦ County medical societies ♦ ISDH/county health departments ♦ HCE medical review workgroups ♦ Academic institutions ♦ Health care providers ♦ Insurance providers	MPS

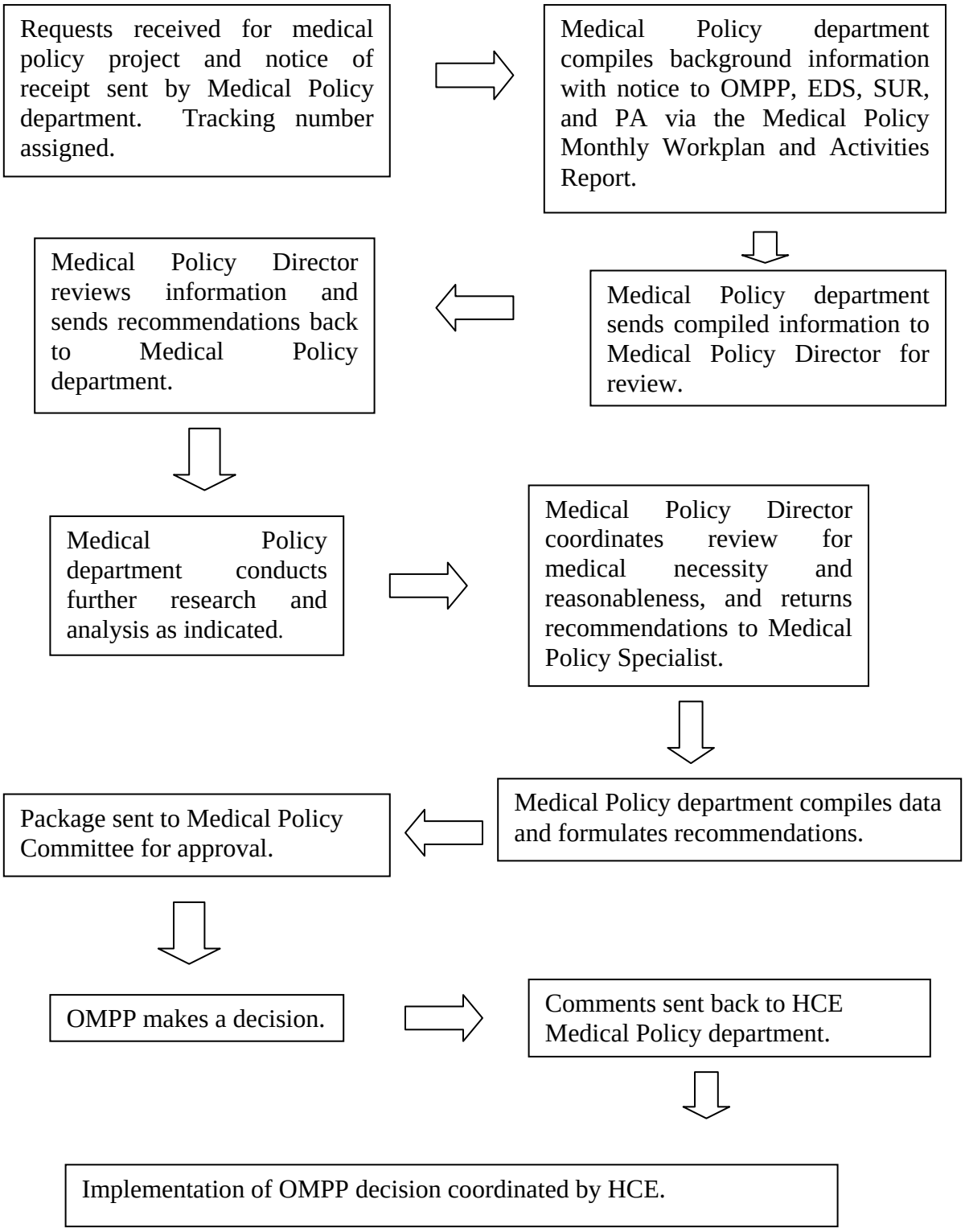
TABLE III-1: **PROJECTS PROCEDURE**
(Continued)

No.	Description of Activity	Responsible Party
	♦ Pharmacists ♦ National Activity ♦ National Library of Medicine literature ♦ Other states ♦ Private groups ♦ Insurance companies ♦ Health care providers ♦ Pharmaceutical companies/associations ♦ Durable Medical Equipment (DME) companies ♦ Other entities ♦ Electronic Data Systems (EDS) ♦ HCE medical review groups ♦ External medical review groups ♦ PA/SUR Departments ♦ OMPP ♦ Managed Care Companies ♦ Other OMPP contractors ♦ DME providers	
12	The additional research and analysis shall be forwarded to the MPD to coordinate further review of the medical appropriateness of the medical policy projects requested in terms of medical necessity and reasonableness.	MPD/MPS

TABLE III-1: **PROJECTS PROCEDURE**
(Continued)

No.	Description of Activity	Responsible Party
13	The MPD shall consult with the panels (representatives from specialty groups) approved by OMPP and HCE medical consultants as necessary.	MPD
14	The MP department shall create a document containing the research, analysis, cost benefit analysis, and recommendations on the medical policy projects request and forward the document to OMPP MP Committee. Cost benefit analysis may cover the entire range of issues in the treatment of the service requested.	MPS /MPD
15	OMPP may request further information from the MP department in order to reach a decision whether to implement a new medical policy. If the new medical policy would require a rule change, OMPP would seek appropriate assistance from its legal department to make the necessary changes.	MPD
16	If OMPP determines that a new medical policy is warranted, OMPP will direct the MP department to implement the new medical policy. The MP department must coordinate with EDS, SUR, and PA to implement the new medical policy. If PA is necessary, the MP department must develop criteria prior to the implementation of the new medical policy with input from PA and SUR. These criteria will be developed for use by both the PA and SUR departments, as necessary.	MPD
17	The MP department will assist all parties to ensure that providers are notified forty-five (45) days prior to implementation; that EDS is notified as soon as HCE and OMPP have determined that the medical policy project change will occur; that all documents and systems are updated; and that the distribution of the new medical policy is completed timely.	MPS/MPD

PROJECT PROCEDURE FLOWCHART



2. MP Projects

The MPD will assign the project to a MPS, who will begin the project Each project will be assigned a unique tracking number to monitor the progress through completion of the issue. The tracking of requests will support the catalog of requests and subsequent actions for all requests, regardless of outcome. The tracking system will be used to generate reports on the volume, type, timeliness, sources, and outcome of the process of issues. Not all issues will result in new, revised, or eliminated medical policy. Therefore, issue management is a more global concept than policy management.

The project tracking number will be assigned using the format YYYY-DDD-XXX-SSS-CC.

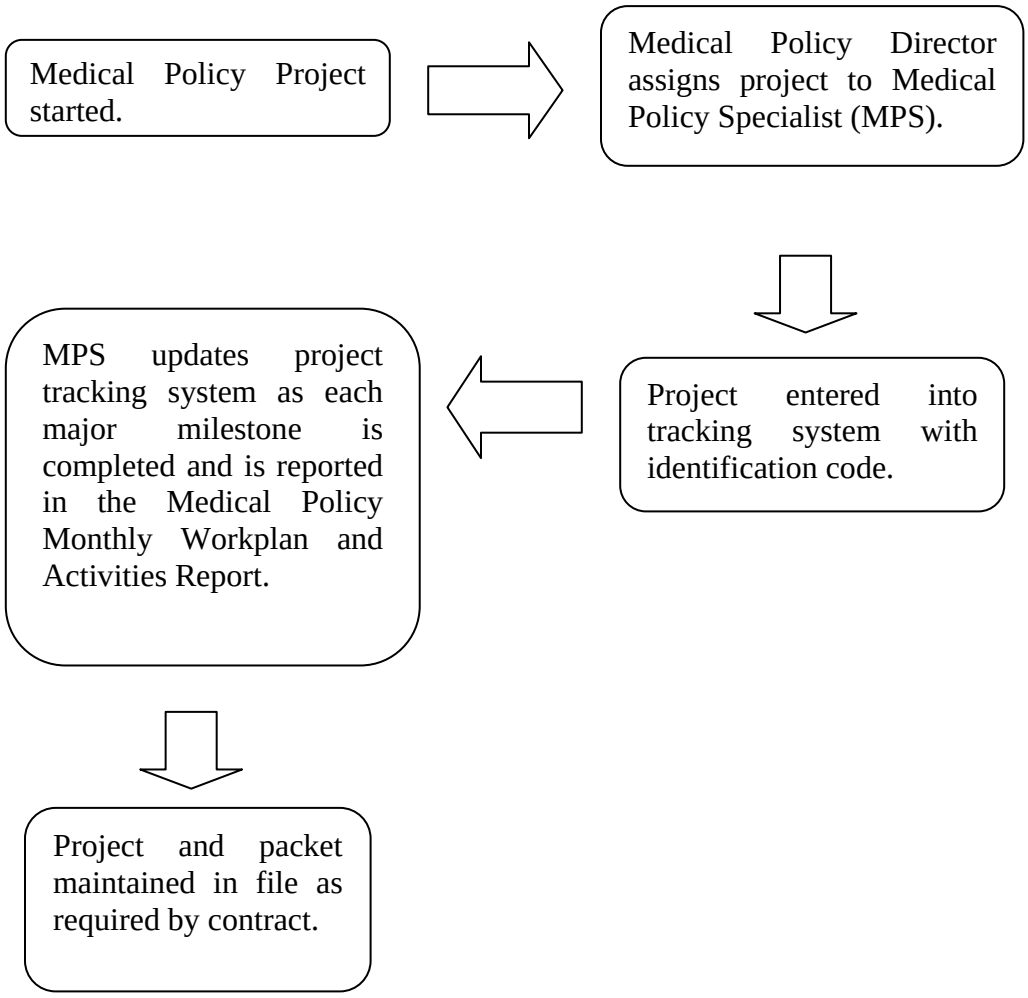
YYYY - represents the year of the request (e.g. 2004)
DDD – represents the Julian date of request (e.g. 041)
XXX – represents that the record is a project (e.g. PRJ)
SSS – represents the assigned number of the MPS and the daily assignment number (e.g. 391)
CC – represents the two digit code of the service category for the project (e.g. DN for Dental)

The MPS will enter the project in the tracking system. **(Refer to Table III-2 and the MP Projects Flowchart.)**

TABLE III-2: PROJECTS PROCEDURE

No.	Description of Activity	Responsible Party
1	The initial request for a medical service review is received and the MPD assigns a MPS to monitor the life cycle of the project. The MPS begins the project.	MPD
2	The project is entered into the tracking system, along with an internal tracking code.	MPS
3	The MPS updates the tracking system as the project completes or goes through major review milestones.	MPS
4	At the completion of the review, and the implementation of the OMPP decisions, the entire packet and project will be maintained in a filing system in the MP department. All files are maintained in an area that is restricted to HCE employees only. All employees will have access to the medical policy files and will be required to document removal of a file by using a sign out card. As files age, they will be retained in accordance with State record and documentation storage requirements.	MPD
5	Updates of all projects with accompanying detailed information may be supplied to OMPP on a routine basis or as requested.	MPS/MPD

MP PROJECTS FLOWCHART



3. New Policies

The MP Manual will contain all medical policies subject to management through the IHCP and will be organized by topics, regardless of the health care delivery system and the program oversight department. Each new issue will be associated with one or more of the topics to promote consistency in policy management and appropriate program communications.

Each new issue associated with an existing policy will be assigned the policy number of that topic, with a sub-number to identify the individual policies under the umbrella topic. To the extent practical, policies will appear in written form with the title of the policy and the unique number. The unique number will assist in tracking the policy through steps to a final resolution of the issue, and should be represented uniformly in written reports, minutes, bulletins, MP Manual, and other written documents.

New issues will be processed using the same approach for modification of policy or the elimination of policy.

4. Evaluation of Existing Policies

For a new request (project), the MP Specialist will evaluate existing policies and pending issues to determine if the request fits an existing category or will require a new policy. After a review of the relevant information, the Specialist will submit the information to the MPD for feedback on the next appropriate step.

A review of the relevant information will include preliminary research on the issue, identification of the steps to completion, timeline recommendations, and brief overall impact if a policy action proceeds to completion. The MPD will assess workload, pending change order requests (COs), pending reference change orders (RCOs), policy priorities, and coordination issues. Clinical discussions will be held with the MD.

5. Communications with OMPP, the MP Committee, and the Requestor

The MPD will communicate with OMPP on the recommendations of whether to proceed with the project, the rationale that supports the recommendations, and any associated timelines for completion. Unless there is a particular urgency within the Health Coverage Programs, the issue will be placed on the agenda for the next scheduled MP Committee meeting, under new business. The information and agenda will be submitted to OMPP 10 business days prior to the scheduled meeting or as requested by OMPP.

In matters of urgency, the MPD will request the OMPP Director of Program Operations to determine how to proceed.

Upon receipt of the response from OMPP, other actions will be undertaken. If the issue will result in new policy, the procedure for new policies will be followed. If the issue will result in revised policy, the steps for modification of policy will be undertaken. For all requests that require that the requestor receive feedback, the MPD will coordinate with OMPP on the appropriate response to the requestor.

In potentially controversial requests, HCE will collect the following information and forward it to the State according to the OMPP communication protocol that is explained in **Table III-1, Step 1, and on the accompanying Project Procedure Flowchart.**

6. Detailed Research, and Formulation of a Fiscal Impact Analysis, Recommendations

The MPS will undertake the appropriate policy research, formulation of fiscal impact, and recommendation tasks.

Where applicable, the MD will assist in the identification of expert consultants, communication with provider associations, and/or the establishment of an advisory panel.

The MPS will identify initial criteria issues pertinent to each issue. Communication and coordination with the PA and SUR departments will be done during the criteria identification process when appropriate.

Research conducted by the MPS must be extensive and exhaustive in scope to ensure that all current, relevant information is available for

fiscal impact statements and recommendations. The MPD facilitates discussions and problem solving as it relates to policies-in-process.

The primary objective of the MPD will be to collaborate, coordinate with the SUR and PA departments, and prepare for the quarterly MP Committee meetings held with the State, EDS, and other appropriate representatives. Preparation for the MP Committee meetings will be completed by HCE to produce optimal results within a reasonable meeting timeframe.

Items to be researched, evaluated, and stated on the medical policy document will include many elements, some of which have been listed below.

- Issue/Policy Identification
- Objectives - short term goals and long term goals
- Background
- Literature and Legal Research
- Indiana*AIM* Issues
- Fiscal Issues
- Potential for Change
- Feasibility Analysis
- Preliminary Studies
- Methodology and Approach
- Development Description
- Data Sources and Collection Methods
- Implementation
- Follow-Up Approach and Interventions
- Recommendations

The pursuit of a comprehensive research and evaluation of the issue or policy will involve a planned, systematic, and effective approach that is uniform to all actions to avoid unnecessary and undesired variations in performance. The checklist, efficient issue/policy tracking, use of a standard medical policy document, and a uniform approach should be part of an array of internal controls to promote a productive outcome during the MP Committee meetings. **(Refer to Table III-3 and the MP Research Procedure Flowchart.)**

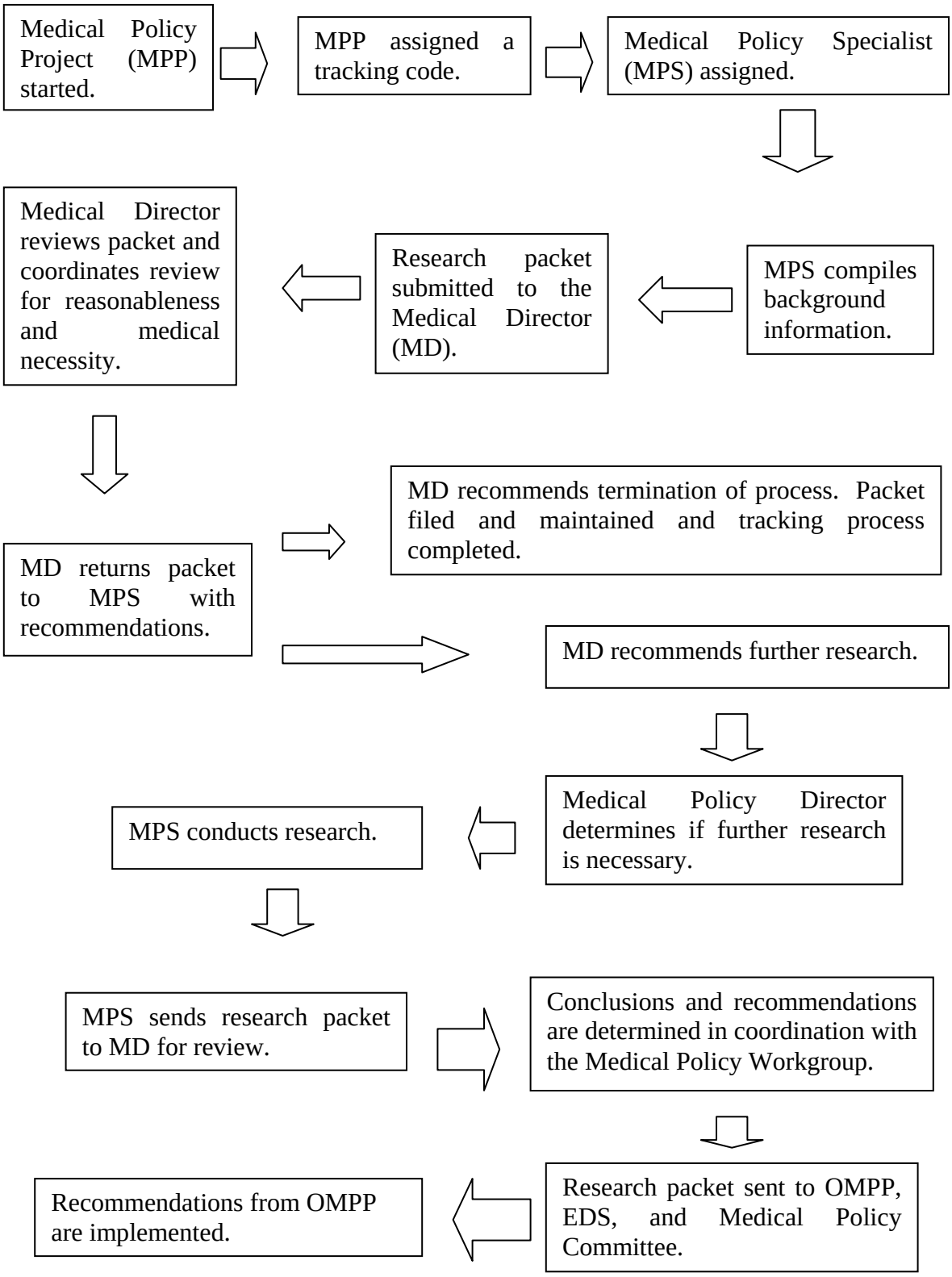
TABLE III-3: MP RESEARCH PROCEDURE

No.	Description of Activity	Responsible Party
1	A MP Project (MPP) is initiated by the designated MPS, and assigned a tracking number.	MPS
2	The MPP is assigned to a MPS to conduct research and analysis.	MPD
3	The MPS compiles background information that includes, at a minimum, the following: ♦ SUR and PA data ♦ Case law review ♦ Statute review ♦ Regulation review	MPS
4	The compiled research packet is submitted to the MD.	MPS
5	The MD performs a review of the entire packet and returns the research packet to the MPS with a recommendation to: ♦ conduct further research, or ♦ terminate the process due to medical inappropriateness.	MD
6	After consultation with the MPD, the MPS conducts any necessary additional research, in collaboration with other HCE staff. The research performed will be specific and appropriate to each issue undergoing review. This research may include the following: ♦ literature review; ♦ epidemiological analysis; ♦ fiscal impact assessment; ♦ review of current clinical practice; and/or ♦ cost benefit analysis	MPS
7	The research packet is forwarded to the MD to coordinate review for medical necessity and reasonableness.	MD
8	The MP department develops conclusions and recommendations.	MP department

TABLE III-3: MP RESEARCH PROCEDURE (Continued)

No.	Description of Activity	Responsible Party
9	A report summarizing the research and recommendations is sent to OMPP, EDS, and the MP Committee, accompanied by the research packet when appropriate.	MPD
10	Approved actions from OMPP are implemented.	MPD

MP RESEARCH FLOWCHART



7. Management of the Project

The active policy will be assigned a target completion date and milestones will be used to monitor progress. The department tickler files will be updated to reflect the key dates for purposes of quality management. The policy will be entered on the monthly integrated MP Projects Report/Workplan for distribution to OMPP, EDS, and other appropriate parties. The issue will be entered for discussion on the agenda at future MP Committee meetings.

Internally, the report will be routinely shared with the MP staff and the OAC. Discussions held among members of the OAC, which includes the individuals listed as members of the report, will enhance internal communications on the MP Projects.

Processing of the policy from initial evaluation throughout completion will be managed through collaboration with OMPP, EDS, and other parties. Management of the policy includes ongoing assessment of the implications of any changes to the IHCP and determination of the approach to the changes. It also involves communications, discussions, and collaboration with provider associations and individuals to promote a comprehensive customer service approach to effective medical policy. Management of timeframes, updating and checking Indiana*AIM*, staff training, and monitoring of the change will ensure all relevant components has been effectively implemented. Change implementation will include an update to the MP Manual when appropriate.

Coordination with EDS will be important to effect timely, comprehensive, and effective change. This will include a broad array of potential activities, including impact on Indiana*AIM*, edits and audits, Reference Files, provider manual, provider training, and publication issues.

B. Medical Policy Committee

HCE will continue the work of the MP Committee through its quarterly meetings with OMPP, EDS, and other appropriate individuals, as approved by OMPP.

1. Schedule of Meetings

Not later than ninety (90) days prior to the start of each calendar year, the MPD will present a proposed schedule for meetings to be held in the next year to the State. A preset day of each quarter will be established, and a calendar of scheduled dates will be distributed not later than sixty (60) days prior to January 1 of each year to all MP Committee participants. It will be the responsibility of HCE to schedule the site of the meeting. The dates of the meetings will be entered on the department operations calendar and will be the dates from which other activities are scheduled. The MD, MPD, and/or the PD and other staff as necessary will attend the meetings on behalf of HCE, depending on the agenda items.

2. Planning Ahead

MP projects will become a source for planning the meeting topics and the allocation of time in the meeting. The projects will be ranked by priority, with those that require discussion supported through appropriate meeting management; other information on the status of active projects may be communicated through written reports.

A proposed list of meeting topics will accompany the annual schedule of meetings, providing an opportunity to adequately prepare for focused discussions and address the spectrum of issues in a logical format with continuity from meeting-to-meeting. However, the meeting schedule will be flexible to accommodate other business. To the extent that these pressing issues are known, they will be listed on the agenda.

3. Meeting Agenda and Materials

HCE will solicit prospective participants for agenda items. The agenda must be sent to the State no later than ten (10) business days, or as specified, prior to the meeting to solicit feedback and approval. Upon receipt of the response from the State, the final agenda will be prepared for distribution with the meeting packet. State suggested changes would be incorporated into the final agenda.

An item will not be returned to the MP Committee agenda until the research has been completed and a recommendation is ready to be made. HCE will include in the agenda an update on the research for any pending items until the research is finalized and a recommendation is made.

Preparation of the agenda and meeting materials will commence upon conclusion of each monthly meeting to schedule the internal actions. The distribution of the agenda and proposed meeting materials to all meeting participants will occur not less than three (3) business days prior to the date of the scheduled meeting. For any items that could not be available, these will be distributed as expeditiously as possible. Every effort will be made to avoid distribution of information at the start of a meeting, as participants would not have been provided with an opportunity to evaluate the contents.

Meeting packets will include a table of contents and all information previously distributed but still on the agenda as old business. Medical policies on the agenda will be clearly identified by title and unique number. A uniform, consistent approach to the identification of the individual policies will support program management and accurate documentation.

Materials to support presentations by the MPD and MPS must be relevant, thorough, and accurate. The assigned MPS presenting the information will facilitate completion of the packets, check all contents, and forward to the MPD and MD the proposed packet at least two (2) business days prior to the scheduled distribution date. Incomplete information will be explained at the time of the distribution of the packets (e.g., receipt of information from an outside source has been delayed). Communications concerning failure of materials to arrive must be made to the MPD.

4. Minutes

The draft minutes will be submitted to the State for review and approval at least ten (10) business days prior to the next meeting, or as specified by the State. The State shall have the option to review the draft minutes at that time and make necessary changes, or convey desired changes at the next meeting. Minutes of the previous meeting will be included in the meeting packet.

The support files for the MP Manual will contain information from any meeting in which the topic was discussed. The topic support file will be accessed and reviewed to identify a previous decision and/or discussion. The minutes of the MP Committee meetings are an important source of information for the history and actions taken on individual medical policies.

C. Medical Policy Manual

IHCP medical policies will be contained in the MP Manual. The Manual will include all active policies. All inactive policies will be placed in an inactive medical policy reference manual. This task will be entered on the work plan for the MP department.

A work-in-process, the MP Manual will be maintained by the MP department. It will contain policies in the official State version and policies-in-process, to serve as a daily reference tool that is representative of all active and inactive policies for a period of one year.

1. Annual Evaluation of Medical Policies

The annual work plan will require an annual evaluation of a specific number of policies scheduled for review. Each calendar year a specified number of policies will be evaluated to support a total evaluation of all policies within a six-year rolling period. Active policies will be reviewed for consistency with current IHCP objectives and prevailing standards of care. Depending on the policy, the review may be brief or extensive. HCE advisory panels and/or expert consultants may be used to facilitate completion of the evaluation process. **(Refer to Table III-4 and the Current MP Flowchart.)**

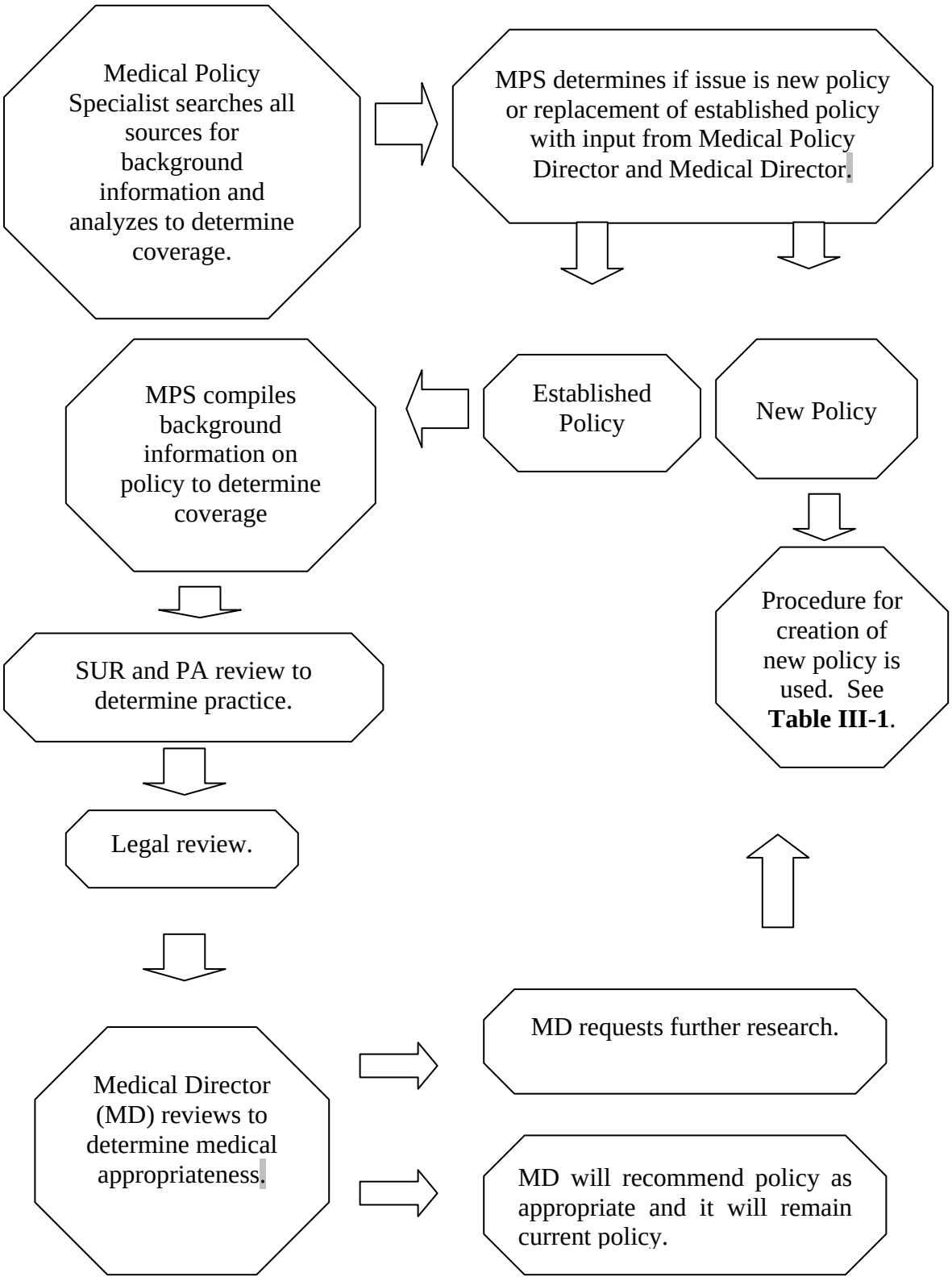
Based on the results of the annual policy review, the MPD, in collaboration with the MD, will propose recommendations for modifications to medical policies. As a result of feedback from OMPP, the policies to be modified, including those to be eliminated, will be entered into the tracking system, assigned a priority ranking, and entered on the MP department work plan.

Each medical policy will have a distinct file. The file will contain relevant information and represent the history of the evolution of the policy through implementation and closure. Medical policy history files will be maintained in accordance with State record retention requirements.

TABLE III-4: CURRENT MP PROCEDURE

No.	Description of Activity	Responsible Party
1.	The MP department will identify current medical policies to be reviewed during calendar year. These policies will be reviewed at least every six years by the MP department to ensure medical necessity and reasonableness.	Medical Policy Manual Coordinator (MPMC)
2.	Emerging policy that requires development of medical policy will be incorporated into quarterly reviews.	MPMC
3.	MPMC will develop a quarterly work plan to complete scheduled review and review with Medical Policy Director (MPD).	MPMC/MPD
4.	Background information will be compiled by the MP department to include current case law, regulations, administrative law judge decisions, and court decisions, IHCP Provider Manual and provider notifications. In addition, review of any system updates will be included.	MPS/MPD
5.	Existing medical policy will be revised in draft form for review by PA and SUR department.	MPS/PA/SUR
6.	Revised medical policy draft will be submitted to the Medical Director (MD) for review of medical appropriateness.	MPS/MD
7.	Revised medical policy draft will be updated according to the MD review and submitted to PA and SUR for second review	MPS/MPD
8.	Legal review if appropriate.	Coordinated by MPMC/MPD
9.	Draft medical policy submitted to MD for review following 2nd PA and SUR review	MPS/MD
10.	Draft medical policy submitted to the IMPRS Program Director (PD)	MPD/PD
11.	Draft medical policy submitted to OMPP for review for new or changed policy.	PD
12.	MP coordinates publication of MP Manual, uploading to M:Drive, and distribution	MPMC/MP Secretary
13.	MPMC updates review schedule.	MPC

CURRENT MP FLOWCHART



D. Procedures for Reference Change Orders for Indiana*AIM*

Coordination with EDS is a critical component to effective medical policy management. Upon approval to activate a change in medical policy that will affect the Reference File, HCE will coordinate with EDS to ensure appropriate communication, completion of form(s), and other activities to facilitate necessary changes to the Reference File as reflected in Table III-5 on the following pages and in the "Reference Change Order Flow Chart" provided by the fiscal agent **(Refer to Page III-28 for a copy of the RCO flow chart).**

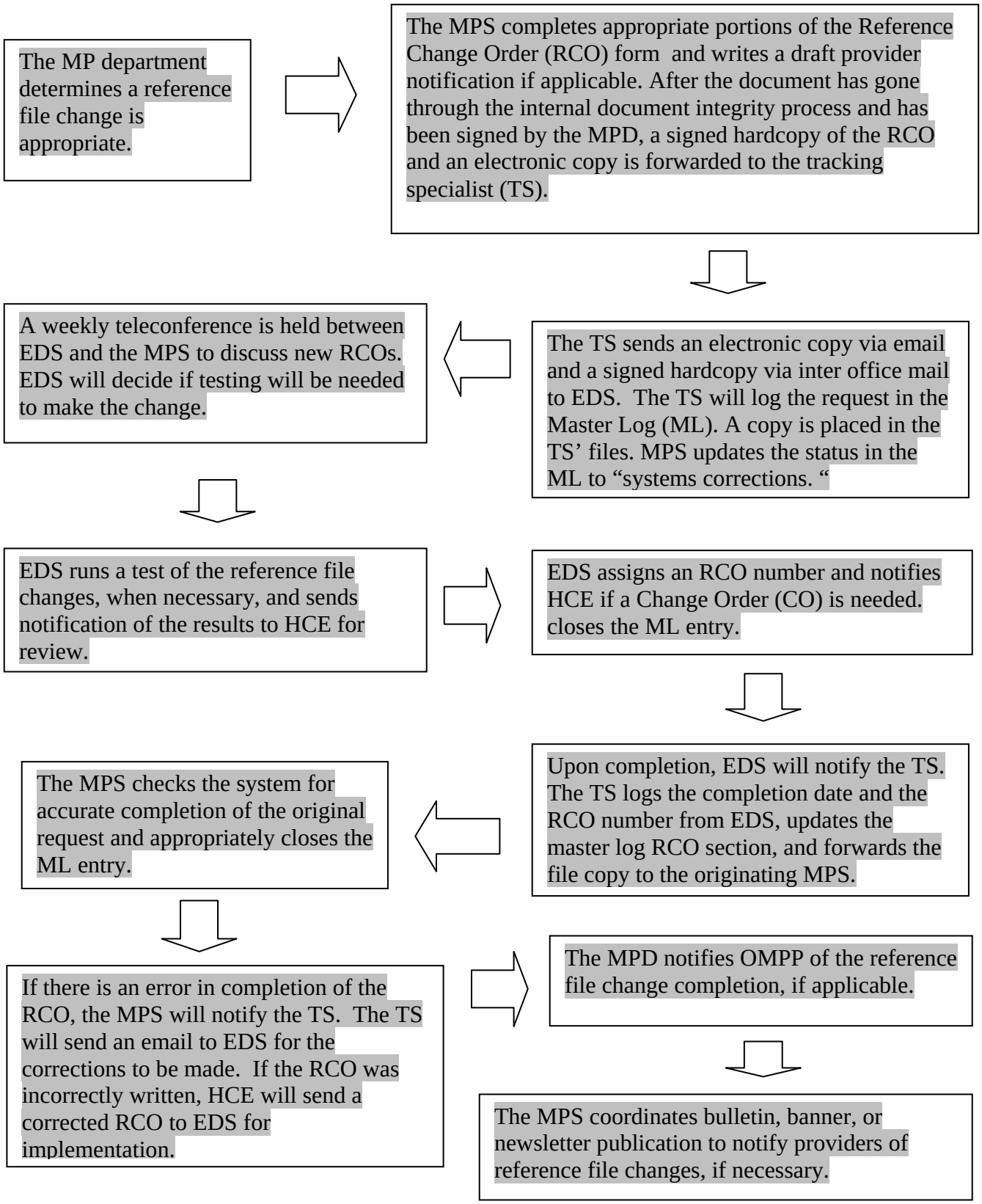
TABLE III-5: REFERENCE CHANGE ORDER PROCEDURE

No.	Description of Activity	Responsible Party
1	The MP department determines a reference file change is appropriate.	MP department
2	The MPS completes appropriate portions of the Reference Change Order (RCO) form (see page III-30 for a copy of the RCO form) and writes a draft provider notification if applicable. After the document has gone through the internal document integrity process and has been signed by the MPD, a signed hardcopy of the RCO and an electronic copy are forwarded to the tracking specialist (TS).	MPD/MPS/TS
3	The TS sends an electronic copy via email and a signed hardcopy via inter office mail to EDS. The TS will log the request in the Master Log (ML). A copy is placed in the TS' files. MPS updates the status in the ML to "systems corrections. "	MPS/TS
4	A weekly teleconference is held between EDS and the MPS to discuss new RCOs. EDS will decide if testing will be needed to make the change.	EDS/MPS
5	EDS runs a test of the reference file changes, when necessary, and sends notification of the results to HCE for review.	EDS/MPD/MPS
6	EDS assigns an RCO number and notifies HCE if a Change Order (CO) is needed.	EDS
7	Upon completion, EDS will notify the TS. The TS logs the completion date and the RCO number from EDS, updates the ML RCO section, and forwards the file copy to the originating MPS.	MPS/TS
8	The MPS checks the system for accurate completion of the original request and appropriately closes the ML entry.	MPS

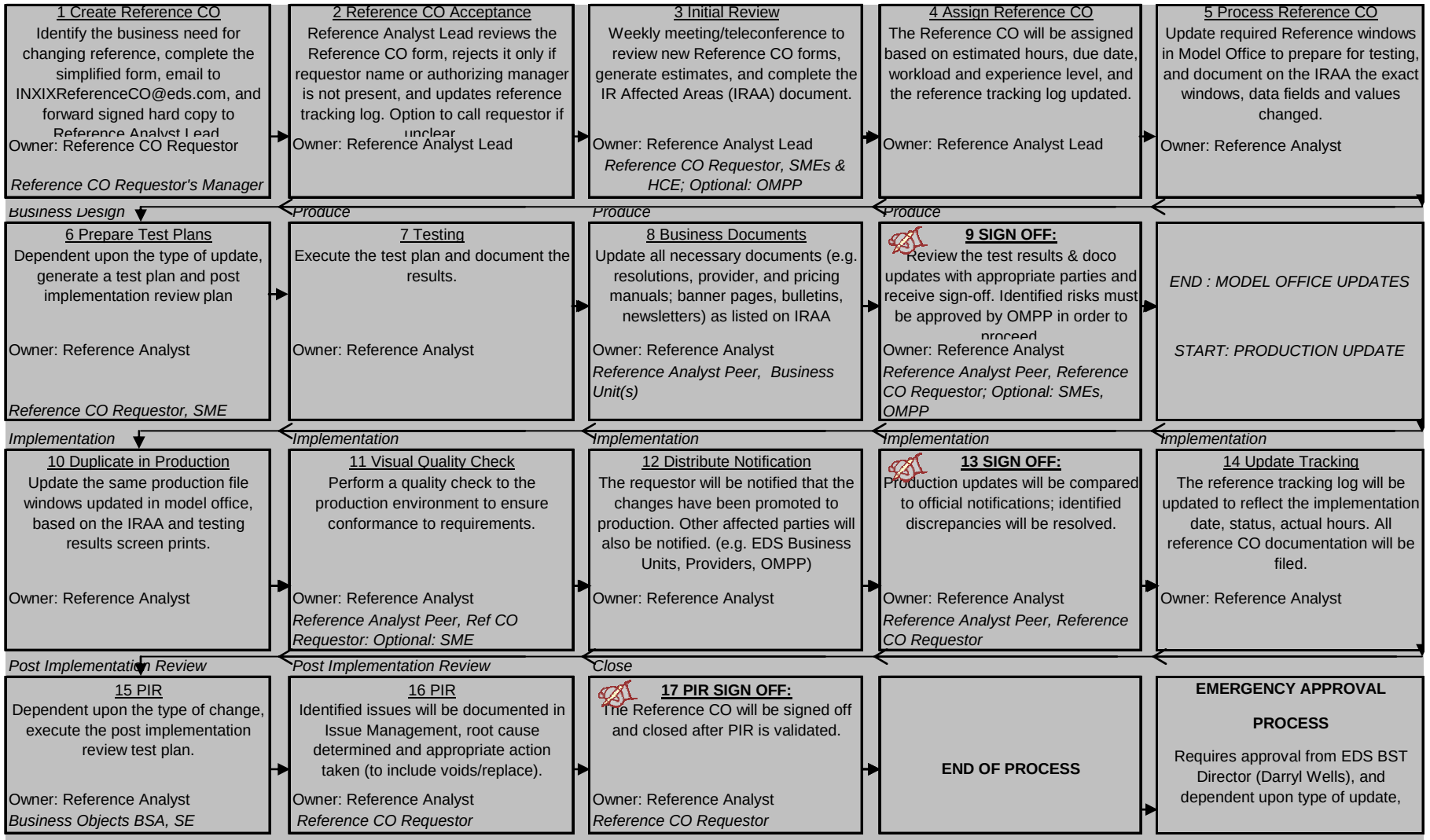
TABLE III-5: REFERENCE CHANGE ORDER PROCEDURE (Continued)

No.	Description of Activity	Responsible Party
9	If there is an error in completion of the RCO, the MPS will notify the TS. The TS will send an email to EDS for the corrections to be made. If the RCO was incorrectly written, HCE will send a corrected RCO to EDS for implementation.	MPS/TS
10	The MPD notifies OMPP of the reference file change completion, if applicable.	MPD
11	The MPS coordinates bulletin, banner, or newsletter publication to notify providers of reference file changes, if necessary.	MPS/EDS

REFERENCE CHANGE ORDER FLOWCHART



LIFE OF A REFERENCE CHANGE ORDER PROCESS FLOW INDIANA XIX



NOTE: The italicized roles listed below the Owner are additional participants in this step of the process.

REFERENCE CHANGE ORDER (RCO) FORM

Requestor Name: **HCE Tracking Number:** **Requestor Phone Number:** **Related Systems Change Order #:** **If applicable** **Date:**	*Internal Use Only:* Reference Change Order #: Reference Analyst Assigned: Date:

Description of Request:

Reason for Change (e.g. new policy, change to existing policy, defect, change order, change to existing code sets):

Desired Business Solution (e.g. effective and end-dates, program coverage, exclusions):

Provider Notification Required?	**IHCP Bulletin/Newsletter**		**IHCP Banner Page Article**	
	45 Day Notice Required?		45 Day Notice Required?	
	No Notice Required?		No Notice Required?	

Manager's Approval Signature: **Date:**	**Reference Approval Signature:** **Date:**	**OMPP Approval (Optional)** **Date:**

E. Procedures for Change Orders Requests (CO) for Indiana*AIM*

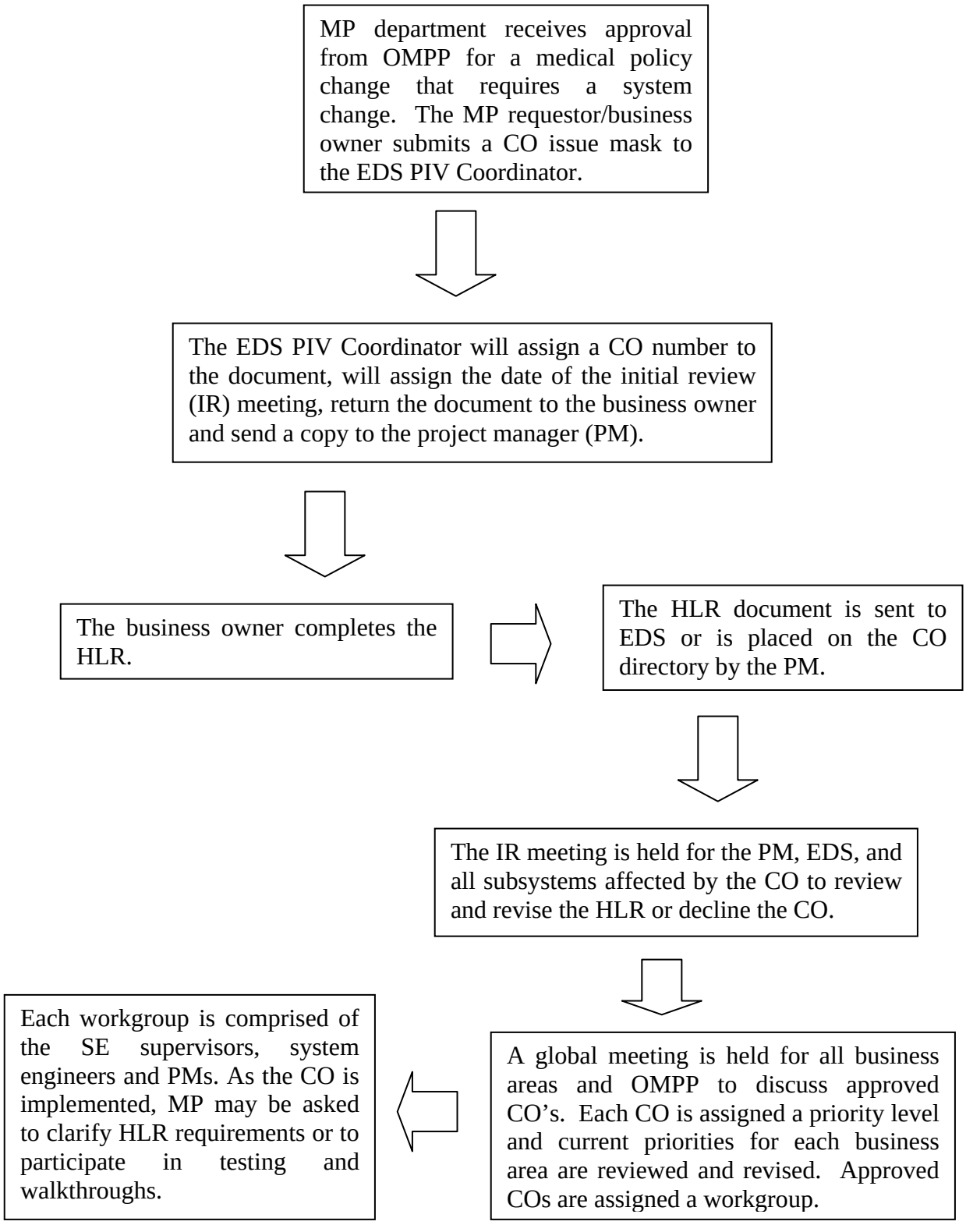
The MP department is responsible for recommending Indiana*AIM* system changes when the need to make changes is identified. These changes are coordinated by OMPP, EDS, and HCE as communicated in the "Life of a Change Order".

Upon approval to activate a change in medical policy that will affect the Indiana*AIM* system. The MPS responsible for implementing the system change will initiate the CO process. **(Refer to Table III-6 and the Change Order Request Procedure Flowchart.)**

TABLE III-6: CHANGE ORDER REQUEST PROCEDURE

No.	Description of Activity	Responsible Party
1	MP department receives approval from OMPP for a medical policy change that requires a system change. The MP requestor/business owner submits a CO issue mask to the EDS PIV Coordinator.	MPD
2	The EDS PIV Coordinator will assign a CO number to the document, will assign the date of the initial review (IR) meeting, return the document to the business owner and send a copy to the project manager (PM).	EDS
3	The business owner completes the High Level Requirement (HLR).	MPD
4	The HLR document is sent to EDS or is placed on the CO directory by the PM.	MPD
5	The IR meeting is held for the PM, EDS, and all subsystems affected by the CO to review and revise the HLR or decline the CO.	MP/EDS/OMPP
6	A global meeting is held for all business areas and OMPP to discuss approved CO's. Each CO is assigned a priority level and current priorities for each business area are reviewed and revised. Approved COs are assigned a workgroup.	MP/EDS/OMPP
7	Each workgroup is comprised of the SE supervisors, system engineers and PMs. As the CO is implemented, MP may be asked to clarify HLR requirements or to participate in testing and walkthroughs.	MP/EDS

CHANGE ORDER REQUEST PROCEDURE FLOWCHART



F. Monitoring of Changes in Law and Government Programs

The MP department of HCE will receive publications and written information related to changes in the IAC, and other State and Federal laws and programs. These include projects undertaken by the Department of Justice and Office of Inspector General. The information may be published in the Indiana Register, Federal Register, or another source, depending on the issue.

The MP department will identify issues that impact the MP business function, as well as the PA and SUR business functions. Wherever desirable, the MP department will collaborate with other key employees on the interpretation and applicability of a change. For changes to Indiana Code, within one week of receipt of the information, the MP department will submit a report to the PD and of the issue as it relates to the IMPRS contract. The MPD will prepare an impact statement and recommendations for action if required. Significant issues will be discussed at the Operations Assessment Committee.

The MPD will share the information with staff and provide direction as a result of potential or actual impact. Whenever appropriate and significant, the issue will be on the agenda for a MP Committee meeting. A copy of the IAC and any amendments thereto will be maintained in the MP department as a reference tool.

G. Medical Criteria

Criteria are used as screening tools by non-physician reviewers. The use of criteria is essential to promoting objectivity and consistency among non-physician reviewers. Criteria support decisions regarding patients' medical care and assist in the assessment for the appropriateness of procedures, imaging studies, referrals, and a current or proposed level of care. Criteria also enable data aggregation on clinical performance.

1. Any department or employee may recognize a need for criteria development, or revision, and initiate action or become involved, as appropriate, in the development process. Criteria should be developed for any newly covered IHCP service and for services where no criteria currently exist.

2. Once the need has been identified, the request will be sent to the MPD.

3. The MP department will coordinate the process to evaluate the issues and gather information. Assistance may be solicited from external

sources, including physicians, providers, and provider associations, as appropriate to the criteria issue.

4. The MP department will formulate a plan of action to address the identified need. Routine updates will be provided to the Operations Assessment Committee during regularly scheduled meetings.

5. The MPD will notify the State through the Medical Policy Monthly Workplan and Activities Report that a criteria project has been undertaken and determine how the State may wish to be involved. Upon receipt of the response, the MD will initiate action

6. Initial and subsequent drafts will be created and distributed for feedback from PA, SUR, and OMPP. For a realistic application, as it may affect decisions on individual cases, the draft criteria will be used on test cases. The results will be conveyed to the MP department for modifications, if any. For purchased criteria that cannot be modified, the implication for an adverse impact on case decisions will be carefully considered.

7. The MP department will formulate a final recommendation on the introduction of the new or revised criteria and submit it to OMPP for review and approval. Information will be conveyed to EDS.

8. If the criteria have been approved for implementation, appropriate providers and associations will be notified of the criteria. To support effective coordination and communications, HCE will work closely with EDS prior to the notification of any provider of a change in the program criteria.

9. All criteria will adhere to a standard format that may contain the following elements.

   - ♦ CPT/HCPCS, Revenue, ICD-9-CM, or DSM IV codes, as applicable.
   - ♦ Narrative description of services or supplies.
   - ♦ Coverage effective date for all newly covered services or supplies.
   - ♦ Citation of regulation or directive for PA, if applicable.
   - ♦ Indications for services or supplies.

- ♦ Level of care (e.g., inpatient, and outpatient), if applicable.
- ♦ Citation of all applicable references.

H. Inquiries and Complaints

The MP department is responsible for handling inquiries received in the department, whether the inquiries are written, by telephone, or in person. All inquiries will be assigned and tracked according to the procedures described in the "Inquiries Assignment and Tracking Process." Some inquiries may be referred to other departments when appropriate. Inquiries from OMPP or other government officials are forwarded to the MPD. All other inquiries are directed to MPSs. If the question being researched is something that cannot be resolved by HCE, the MPS will forward to the appropriate EDS personnel. The MP department is responsible for coordination with EDS. **(Refer to Table III-7, Table III-7A, and the Inquiries Assignment and Tracking Process.)**

The MP department utilizes a "call monitoring" procedure to ensure that customers receive courteous, timely, and accurate information. The results of the monitoring are provided to the MPD. Adverse survey results may result in staff training or corrective action plans if necessary.

Complaints about HCE's customer service are also researched and resolved as outlined in the Complaint procedure. All complaints are tracked internally by HCE as part of the Quality Management process. **(Refer to Table III-8 and the Complaints Procedure Flowchart.)**

TABLE III-7: INQUIRY PROCEDURE WHEN INQUIRIES ARE IMMEDIATELY ANSWERED BY TELEPHONE

No.	Description of Activity	Responsible Party
1	The MPS begins the MP Inquiry form, and obtains as much information as possible, including the provider number, internal control number and/or member number when applicable.	MPS
2	The MPS researches the question and responds to the inquirer.	MPS
3	The MPS completes the MP Inquiry form with the response given.	MPS
4	If the inquiry needs resolution by EDS, the MPS forwards the inquiry via e-mail to the appropriate EDS personnel. If the inquiry is a customer service complaint, the MPS follows the complaint procedure.	MPS
5	The completed form(s) and any research documentation are forwarded to the MPD for review. If it is an EDS inquiry, the MPD contacts the EDS point of contact.	MPD
6	The MP Secretary or assigned MPS logs the inquiry onto the Inquiry Log and files the completed copy of the Inquiry form with any attached documentation.	MP Secretary/MPS

TABLE III-7A: STATE INQUIRY PROCEDURE

No.	Description of Activity	Responsible Party
1	Inquiry is received from OMPP.	MPD
2	Inquiry is assigned to appropriate MPS.	MPD
3	The MPS researches the question and prepares a draft response according to the instructions received from OMPP. Responses are due in three days of receipt, or as agreed.	MPS
4	If the inquiry needs resolution by EDS, the MPS also completes the EDS Provider Issue Inquiry form. If the inquiry is a customer service complaint, the MPS follows the complaint procedure.	MPS
5	The MPS completes the MP Editing and Integrity form and provides all information to another MPS responsible for editing/integrity (MPSE).	MPS
6	The MPSE edits the document and requests any necessary corrections from the MPS.	MPS
7	The draft response, completed review form(s) and any research documentation are forwarded to the MPD, MD, and PD for review.	MPS
8	After all reviews are completed, any necessary corrections are made by the MPS. The MPS is responsible for sending responses to OMPP electronically and hard copy.	MPS

INQUIRY ASSIGNMENT AND TRACKING PROCESS

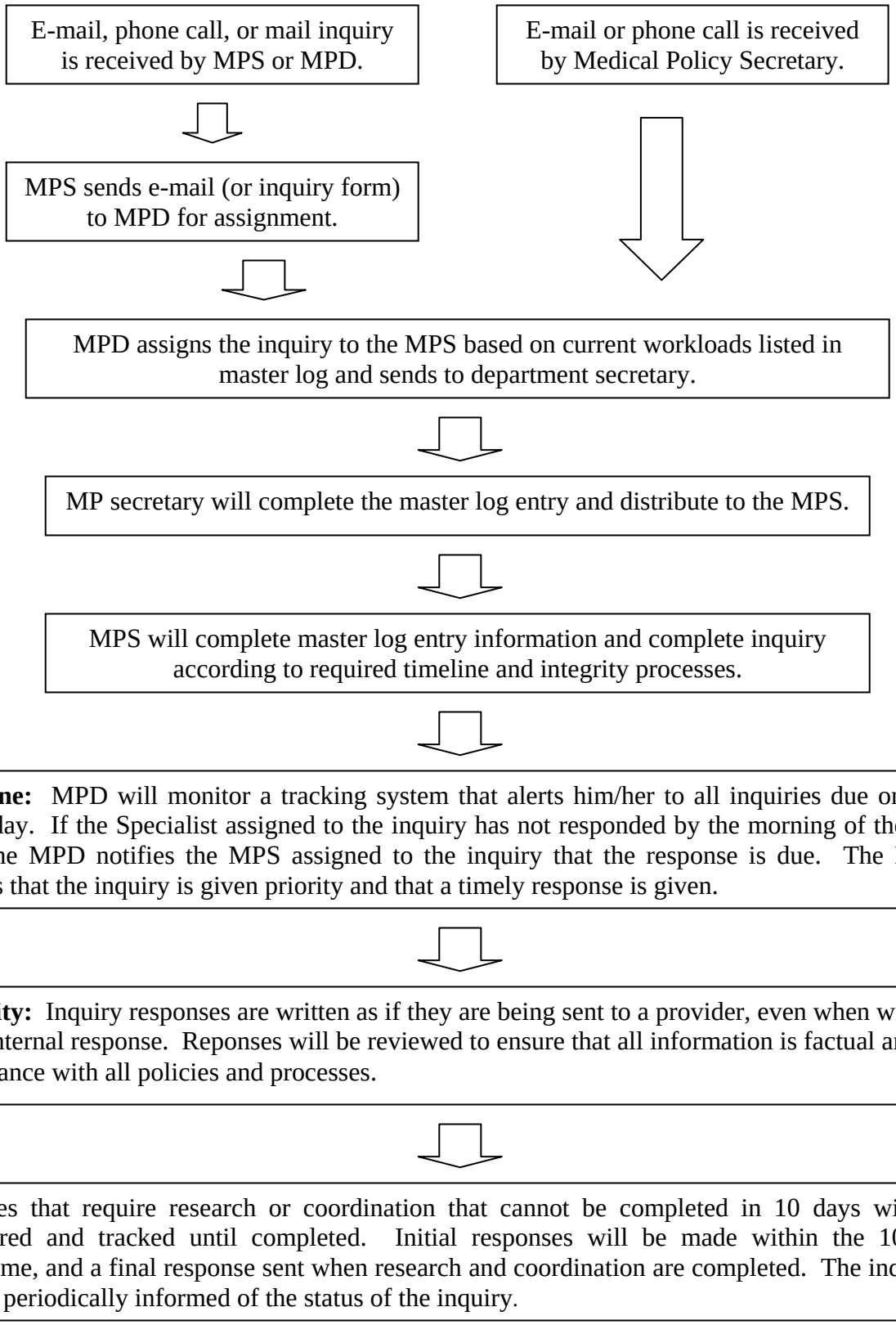
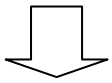


TABLE III-8: COMPLAINT PROCEDURE

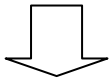
No.	Description of Activity	Responsible Party
1	The MPS completes the complaint form and documents as much information as possible, including provider number, internal control number and/or member number where necessary and any historical information about the complaint. The completed form is forwarded immediately to the designated MPD.	MPS
2	The MPD logs the complaint onto the complaint tracking log.	MPD
3	The MPD reviews the completed complaint form and immediately forwards a copy to the PD, who is responsible for Quality Management complaint tracking. The MPD takes appropriate action to resolve the complaint if it involves the MP department.	MPD/PD
4	The PD sends a receipt notice within 3 days after receiving the complaint, along with an estimated date of response.	PD
5	The MP Secretary files the complaint form.	MP Secretary

COMPLAINT PROCEDURE FLOWCHART

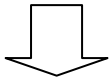
The MPS completes the complaint form and forwards it immediately to the MPD.



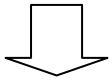
The MPD logs the complaint onto the complaint tracking log.



The MPD reviews the complaint and forwards it immediately to the PD.



If the complaint involves the MP department, the MPD takes appropriate action.



The MP secretary files the complaint form.

I. Internal Referrals

1. Referrals from the Surveillance and Utilization Review department to the Medical Policy department

For internal referrals from the Surveillance and Utilization department to the Medical Policy department, the following information will be forwarded to the Medical Policy Secretary or the Medical Policy Director, via electronic mail. The information should be inclusive of sufficient detail to facilitate Medical Policy's review of the matter being forwarded for resolution, including the following:

- Response to Be Sent To:
- Response Needed By:
- Name of Reporting Department Director:
- Telephone/ Extension:
- Date of Referral:
- Date:
- Recipient ID (if applicable)
- ICNs (if applicable)
- Name of Concerned Party (provider), if applicable:
- Address of Concerned Party (provider), if applicable:
- City, State, Zip of Concerned Party
- Telephone of Concerned Party
- Issue:
- Other Details (claim numbers, special instructions)
- Intended Use of Response (recoupment, association meeting, education):
- References that have already been reviewed, such as the IAC, IC, IHCP Manual, etc.

2. Referrals from the Prior Authorization department to the Medical Policy department

For internal referrals from the Prior Authorization department to the Medical Policy department, the following information will be forwarded to the Medical Policy Secretary or the Medical Policy Director, via electronic mail, inclusive of sufficient detail to facilitate Medical Policy's review of the matter being forwarded for resolution, including the following:

- Response to Be Sent To:
- Response Needed By:

- Name of Reporting Department Director:
- Telephone/ Extension:
- Date of Referral:
- Date:
- Recipient ID (if applicable)
- ICNs (if applicable)
- Name of Concerned Party (provider), if applicable:
- Address of Concerned Party (provider), if applicable:
- City, State, Zip of Concerned Party
- Telephone of Concerned Party
- Issue:
- Other Details (claim numbers, special instructions)
- Intended Use of Response (recoupment, association meeting, education):
- References that have already been reviewed, such as the IAC, IC, IHCP Manual, etc.

3. Referrals from the Medical Policy department to the Surveillance and Utilization Review department

For internal referrals from the Medical Policy department to the Surveillance and Utilization Review department, the following information will be forwarded to the Surveillance and Utilization Review Director or other designee, via electronic mail. The information should be inclusive of sufficient detail to facilitate the Surveillance and Utilization Review department's review of the matter being forwarded for resolution, including the following:

- Response to Be Sent To:
- Response Needed By:
- Name of Reporting Department Director:
- Telephone/ Extension:
- Date of Referral:
- Date:
- Recipient ID (if applicable)
- ICNs (if applicable)
- Name of Concerned Party (provider), if applicable:
- Address of Concerned Party (provider), if applicable:
- City, State, Zip of Concerned Party
- Telephone of Concerned Party
- Issue:
- Other Details (claim numbers, special instructions)
- Intended Use of Response (recoupment, association meeting,

education):

- References that have already been reviewed, such as the IAC, IC, IHCP manual, etc.

4. Referrals from the Medical Policy department to the Prior Authorization department

For internal referrals from the Medical Policy department to the Prior Authorization department, the following information will be forwarded to the Prior Authorization Director or other designee, via electronic mail. The information should be inclusive of sufficient detail to facilitate the Prior Authorization department's review of the matter being forwarded for resolution, including the following:

- Response to Be Sent To:
- Response Needed By:
- Name of Reporting Department Director:
- Telephone/ Extension:
- Date of Referral:
- Date:
- Recipient ID (if applicable)
- ICNs (if applicable)
- Name of Concerned Party (provider), if applicable:
- Address of Concerned Party (provider), if applicable:
- City, State, Zip of Concerned Party
- Telephone of Concerned Party
- Issue:
- Other Details (claim numbers, special instructions)
- Intended Use of Response (recoupment, association meeting, education):
- References that have already been reviewed, such as the IAC, IC, IHCP manual, etc.

5. When Electronic Mail is Unavailable

When Electronic Mail is unavailable, all referrals between departments will be made via completion of a hard copy Internal Referral Form forwarded to the Department Director, inclusive of the following information:

- Response to Be Sent To:
- Response Needed By:
- Name of Reporting Department Director:

- Telephone/ Extension:
- Date of Referral:
- Date:
- Recipient ID (if applicable)
- ICNs (if applicable)
- Name of Concerned Party (provider), if applicable:
- Address of Concerned Party (provider), if applicable:
- City, State, Zip of Concerned Party
- Telephone of Concerned Party
- Issue:
- Other Details (claim numbers, special instructions)
- Intended Use of Response (recoupment, association meeting, education):
- References that have already been reviewed, such as the IAC, IC, IHCP manual, etc.

6. Upon Receipt of a Referral—Medical Policy

Upon receipt of a referral, the Medical Policy Secretary will enter the relevant information into the Master Log Database. The MP Secretary will work with the MP Director to determine which Medical Policy Specialist should be assigned the task of reviewing the referral**.** (Refer to page III-34 for more information on the process for handling inquiries and complaints.)

J. Procedure Identification Code (PIC) Request

The MP department is responsible for evaluating new PIC code requests for the Indiana Health Coverage Programs Indiana*AIM* system. The requesting contractor, EDS or HCE, will coordinate the recommendations received by OMPP, EDS, and HCE, and implement in the Indiana*AIM* system. **(Refer to Table III-9 and PIC Code Request Flow Chart)**

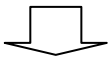
TABLE III-9 – NEW PIC CODE REQUEST

No.	Description of Activity	Responsible Party
1	PIC code request submitted to HCE Medical Policy.	Requestor*
2	HCE Medical Policy evaluates the request. ♦ Review current codes for the product or service ♦ Review applicability of pricing segments ♦ Evaluate current code(s) that could be used in combination with a modifier ♦ Review web site for recent code updates ♦ Send notification of findings to the requestor* in agreement or disagreement with the PIC request	MPS
3	Submit the PIC request to EDS Reference File Team for code/modifier combination system alternatives.	Requestor*
4	Forward the recommendation to OMPP (including Managed Care).	Requestor*
5	Submit an RCO to the EDS Reference File Team for Indiana*AIM* Model testing.	Requestor*/EDS
6	Upon successful completion and approval of Indiana*AIM* Model testing, publish provider notification.	Requestor*
7	Upon successful completion of Indiana*AIM* Model testing, EDS Reference File Team enters the PIC code into Indiana*AIM* Production.	EDS
8	Verify system changes.	Requestor*

* The “requestor” refers to the contractor that initiates the request; EDS or HCE

PIC CODE REQUEST FLOWCHART

PIC code request submitted to HCE Medical Policy.



HCE Medical Policy evaluates the request.

- Review current codes for the product or service
- Review applicability of pricing segments
- Evaluate current code(s) that could be used in combination with a modifier
- Review web site for recent code updates

Send notification of findings to the requestor* in agreement or disagreement with the PIC request

Submit the PIC request to EDS Reference File Team for code/modifier combination system alternatives.

Forward the recommendation to OMPP (including Managed Care).

Submit an RCO to the EDS Reference File Team for Indiana*AIM* Model testing.

Upon successful completion and approval of Indiana*AIM* Model testing, publish provider notification.

Upon successful completion of Indiana*AIM* Model testing, EDS Reference File Team enters the PIC code into Indiana*AIM* Production.

Verify system changes.

K. Review of HCPCS Codes for Federally Qualified Health Centers (FQHC) and Rural Health Center (RHC) Encounters

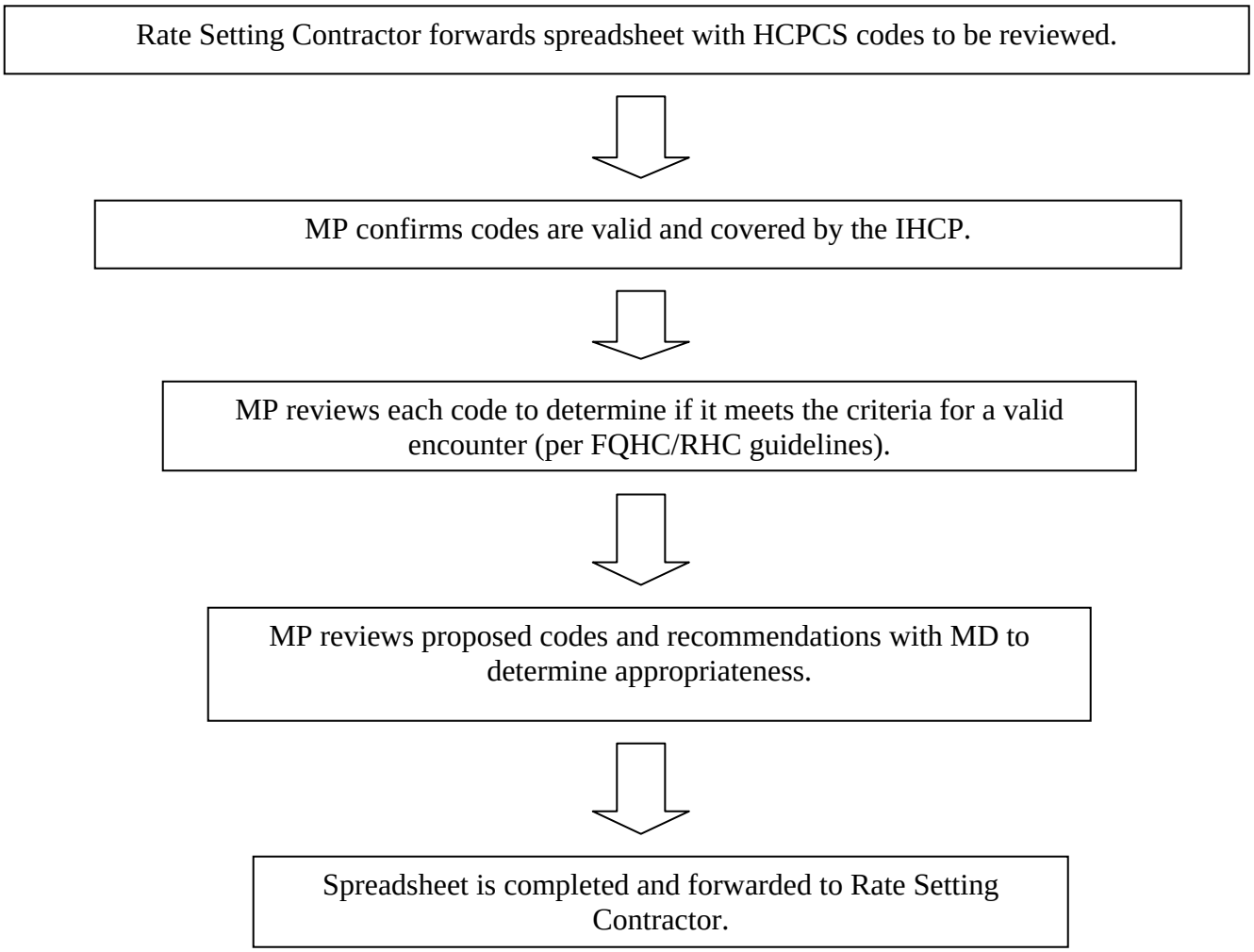
The MP department will review codes requested by the Rate Setting Contractor (RSC) and recommend coverage as valid encounters for FQHC and RHC providers. The following criteria must be met for a service to be considered a valid encounter.

- A valid encounter is available to FQHCs and RHCs for services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, or clinical social workers.
- A valid encounter means a face-to-face medical visit between a patient and one of providers noted above, who exercises independent judgment in the provision of health care services.
- Dental services that must be performed by a licensed dentist are considered valid encounters when performed in an FQHC or RHC. CDT codes will be reviewed for recommendation of coverage as valid encounters.
- Services provided at FQHC and RHC locations that do not require a face to face medical visit as described above will be considered non-valid encounters.

TABLE III-10 – FQHC/RHC ENCOUNTER CODE REVIEW PROCEDURE

No.	Description of Activity	Responsible Party
1	Rate Setting Contractor forwards spreadsheet with HCPCS codes to be reviewed.	RSC
2	MP confirms codes are valid and covered by the IHCP.	MPS
3	MP reviews each code to determine if it meets the criteria for a valid encounter (per FQHC/RHC guidelines).	MPS
4	MP reviews proposed codes and recommendations with MD to determine appropriateness.	MPS/MD
5	Spreadsheet is completed and forwarded to Rate Setting Contractor.	MPS

FQHC/RHC REVIEW FLOWCHART



L. HCPCS Update Coordination

The Centers for Medicare and Medicaid Services (CMS) makes changes to the Healthcare Common Procedure Coding System (HCPCS). OMPP, EDS, and the HCE MP department coordinate the implementation of these changes to the Indiana*AIM* system. **(Refer to Table III-11 and Table III-12)**

TABLE III–11: HCPCS BUSINESS PROCESS

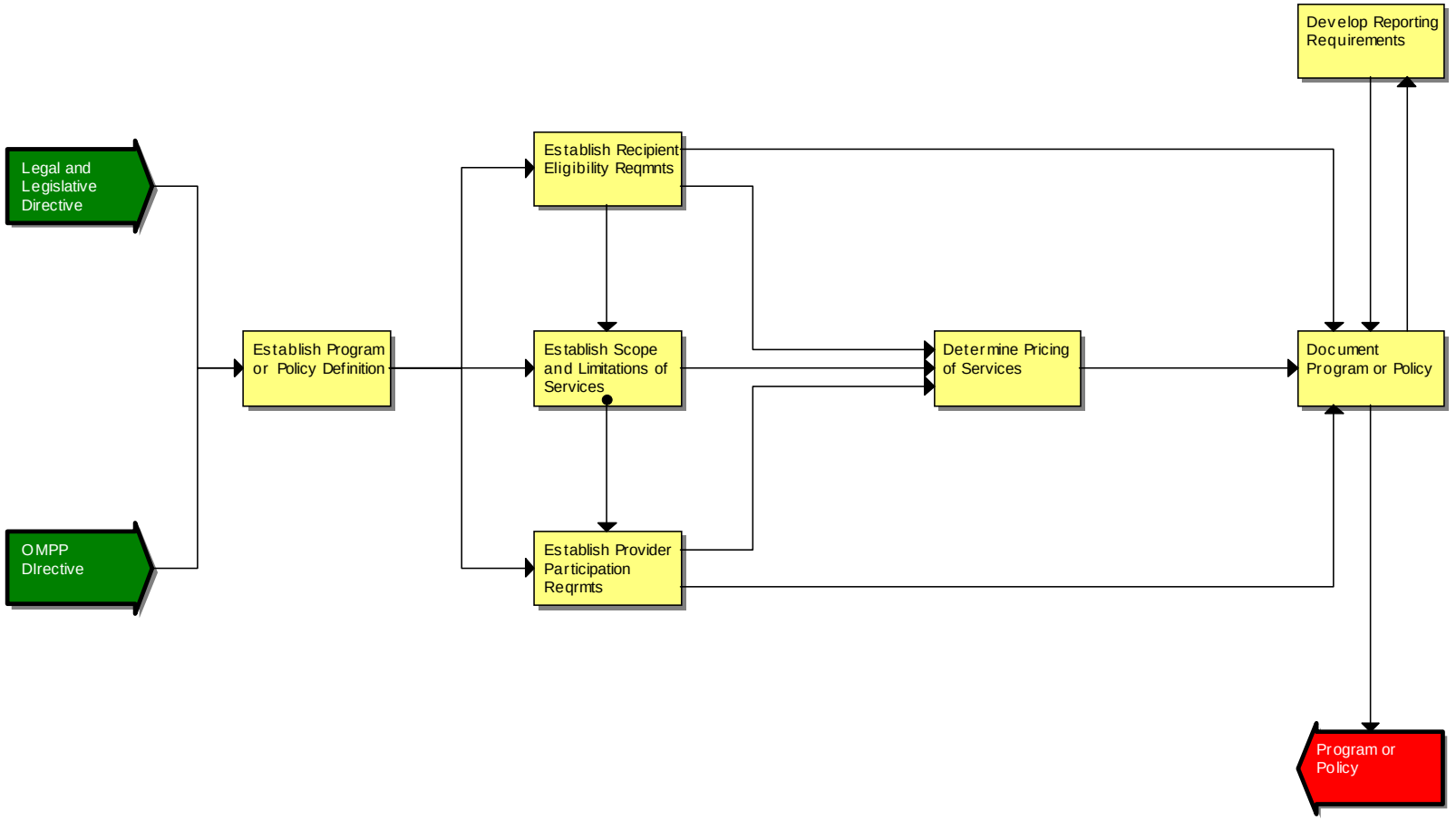


TABLE III–11: HCPCS BUSINESS PROCESS
(continued)

Policy	Description
Establish Program or Policy Definition	Current policy –Does the service fit into current policy or require new policy? Research/Identify standards in the medical community IC 4-22-2 Adoption of Administrative Rules IC 12-15-13-0.7 Conform to directives from the CMS IC 12-15-13-6 A change to Medicaid policy that does not require use of the rulemaking process under IC 4-22-2;
Establish Program or Policy Definition - Continued	Changes are effective 45 days after the date the notice or bulletin is mailed (Providers do not have to receive advance notice of changes that are beneficial to them) IC 12-15-13-7.2 - Not more than 90 days after the effective date of diagnostic or procedure codes the office must start using the following and the provider must submit the following: CPT, ICD, DSM, CDT, HCPCS, TPA Use the code that is in effect at the time of service
Establish Recipient Eligibility Requirements	Provider Manual Chapter 2, Member Eligibility and Services 405 IAC 5-3-7 lists eligibility requirements New services covered for what existing programs? New coverage group?
Establish Scope and Limitations of Services	IC 12-15-5-1 The IHCP services and supplies listed with exclusions 405 IAC 5-10-5, 5-19-18, 5-29-1, 5-30-3
Establish Provider Participation Requirements	Provider Manual Chapter 4, Provider Eligibility and Responsibilities, Scope of practice regulations or statutes (Federal and State); acceptable practices in the medical community Determine provider requirements for provision of services Who can provide? Incorporate codes into provider code sets

TABLE III–11: HCPCS BUSINESS PROCESS
(continued)

Policy	Description
Determine Pricing of Services	Download pricing schedules from the CMS Website (Lab, Physician, DME,) NDC pricing for drugs Manual pricing - services without pricing recommendations Periodic review of fee schedules for pricing updates Compare pricing differences between programs Assess pricing differences between states and Medicare
Document Program or Policy	Document IAC policy in the Access database sheet
Develop Reporting Requirements	Update reporting systems Indiana*AIM* screens Access database screens Update reporting output Banner, bulletin and newsletter provider notification Access database screen prints Fee schedule

TABLE III–11: HCPCS BUSINESS PROCESS
(continued)

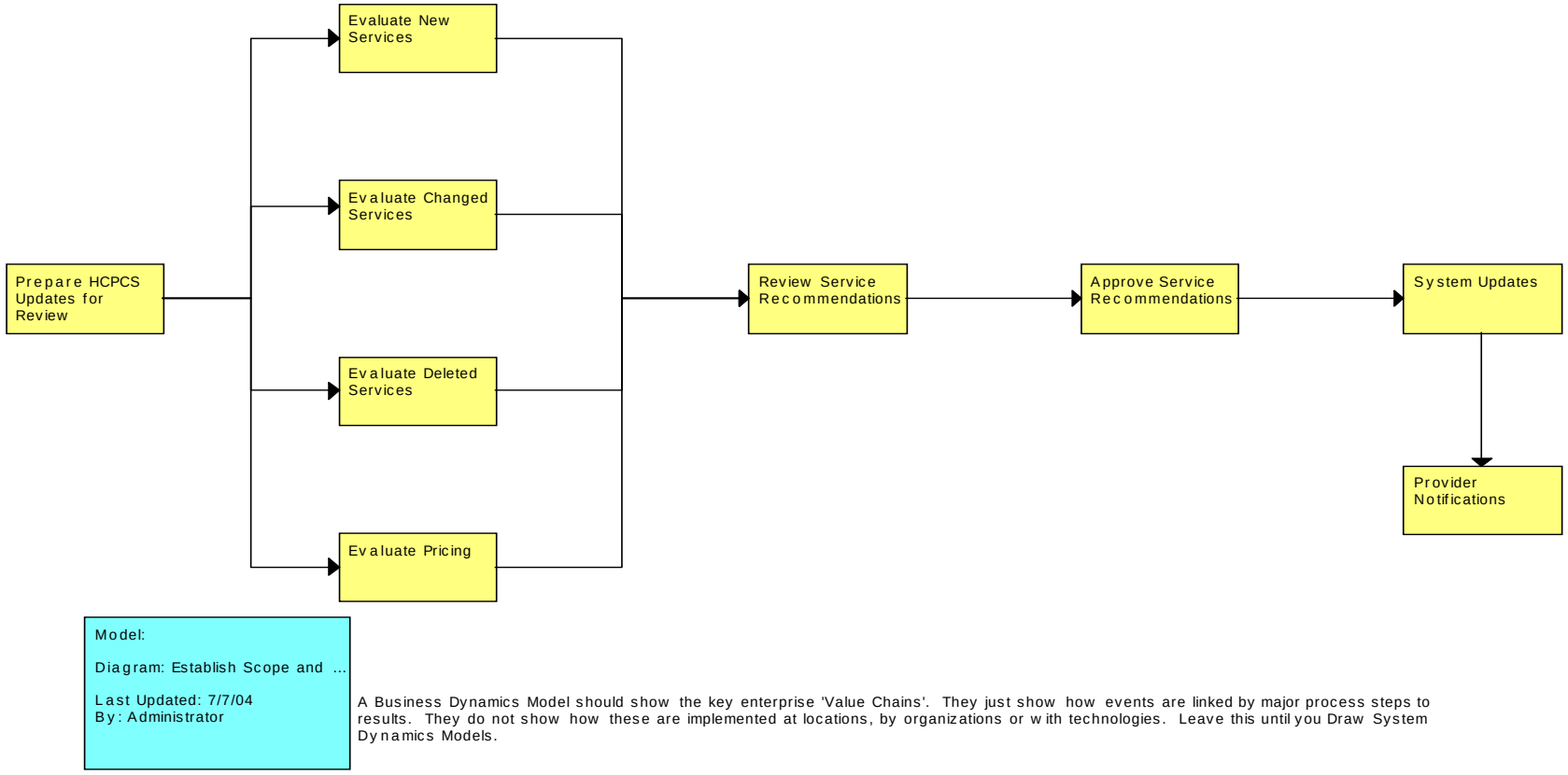


TABLE III–11: HCPCS BUSINESS PROCESS
(continued)

Process	Description
Prepare HCPCS Updates for Review	This process gathers HCPCS related information from various sources, then assigns the data to the various categories that will be reviewed. Updates occur quarterly, and annually. The annual update includes all codes including the quarterly updates, and HCPCS codes as well as CPT codes. The quarterly update only contains alphanumeric HCPCS code updates. Tasks in the business process will be applied to the quarterly updates as appropriate. Modifiers are also included in the updates. Effective dates of the various codes must coincide with the dates assigned on the HCPCS updates. Deleted codes and their replacements must be billable based on their effective dates. Deleted codes must be a priority. Provider notice must be released 45 days before the effective date of the deletion. **HCE** trains specialists on the HCPCS Review process. **OMPP** receives the CMS tape and sends to EDS. **EDS** receives the tape from OMPP, and splits the codes into adds, changes, and deletes based on the indicator on the tape. Those codes that do not change are ignored for the HCPCS review process. The codes are put into spreadsheets for transmittal to HCE. Adds are loaded into AIM as non-covered services pending HCPCS review. **HCE** loads the spreadsheets into the Access database, and assigns codes to the appropriate staff member. **EDS** downloads Indiana RVU pricing from the Physician, DMERC, and Lab pricing fee schedules from the Medicare Web site. EDS loads pricing for all new services on the file. New services that do not have RVU pricing are loaded into AIM with a default pricing indicator of RBRVS and a default price of zero, and are identified for further review.

TABLE III–11: HCPCS BUSINESS PROCESS
(continued)

Process	Description
Prepare HCPCS Updates for Review (continued)	**EDS** attaches modifier of TC and 26 to the procedure code if they are found on the Physician Fee Schedule attached to the procedure. **EDS** attaches the following modifiers to surgery codes, depending on the 'Bilateral Surgery', 'Multiple Procedure', 'Global Surgery', 'Assistant at Surgery, 'Co-Surgeons', or 'Team Surgeons' fields on the Medicare Fee Schedule: 'LT', 'RT', '50', '51', '54', '55', '57', '58', '62', '66', '76', '77', '78', '79', '80', '81', '82', and 'AS'. **EDS** end-dates all codes that are marked 'Deleted' on the HCPCS tape. The end-date must coincide with the end date on the tape. **EDS** reviews pricing and system implementation.
Evaluate New Services	**EDS** Automatically loads all new codes as non-covered. **EDS** Reference file has issues here because of keying that needs to be accomplished. **Can we automate the designation to covered?** Send HCE spreadsheets for Add codes Code and modifier updates with pricing (physician, lab, DME, anesthesia RVUs) • This spreadsheet contains the Procedure Code, Short, EOMB, and Long Description, Add Date, Effective Date, Medicare Coverage Indicator, Global Period, and Modifiers that were loaded

TABLE III–11: HCPCS BUSINESS PROCESS
(continued)

Process	Description
Evaluate New Services (continued)	New Modifiers • This spreadsheet contains the Modifier Code, Modifier Description, Add Date • and Effective Date Codes that are being reused by CMS • This spreadsheet contains the Procedure Code, Short Description, AIM Effective Date, and AIM End Date Descriptions over 250 characters • This spreadsheet contains the Procedure Code, Short, and Long Description, and the Length of the Long Description Current active error code list (edits and audits) • This spreadsheet contains the Error Code, Error Description, Allow CCF Indicator, Allow Deny Indicator, Allow Override Indicator, Cost Containment Indicator, Header/Detail Indicator, and Location Code Codes with ICIC indicated • This spreadsheet contains the Procedure Code, Short Description, and Pricing Indicator, if not Manual Codes with Normal Pricing (Normal pricing is no longer used for new codes) • This spreadsheet contains the Procedure Code and Short Description D codes with minimum age requirements • This spreadsheet contains the Procedure Code, Short Description, Minimum Age and Maximum Age

TABLE III–11: HCPCS BUSINESS PROCESS
(continued)

Process	Description
Evaluate New Services (continued)	**EDS** PIC Codes • This spreadsheet contains a list of all current PIC codes in the system **HCE** Review all codes for new services, or technology Identify codes that should be covered, codes that need additional review, and codes that should be non-covered Review new codes for PIC replacement Add code is a non-covered service • Code will remain non-covered in the system Add code is a covered service, but covered under another code • Non-reimbursable code, state what code the service is covered under (Radiology - CPT code vs. HCPCS G code) Add code is a covered service • Cover code and review description, modifiers, pricing, PA, and additional limits and restrictions Add code to appropriate provider code set Review all codes for code sets that are being expanded or condensed • Services that are currently covered, like codes will be covered

TABLE III–11: HCPCS BUSINESS PROCESS
(continued)

Process	Description
Evaluate New Services (continued)	Review applicable audits and edits • Audit 6096 – FQHC/RHC Review applicable procedure groups (MAR, FQHC, Nursing Home Per Diem) For clarification of definitions send a request to EDS Systems (Jim Snapp)
Evaluate Changed Services	**EDS** Automatically loads all description changes Send HCE spreadsheets for Changed codes: Descriptions of Changed codes • This spreadsheet contains the Procedure Code, Short, EOMB, and Long Description, Procedure Add Date, and Change Effective Date Change descriptions too long (> 250 characters) • This spreadsheet contains the Procedure Code, Short, EOMB, and Long Description, and Length of the Long Description **HCE** Changed code is non-covered • No review necessary Changed code is covered • Review team will evaluate the changed description • Affects pricing, and/or limits and restrictions

TABLE III–11: HCPCS BUSINESS PROCESS
(continued)

Process	Description
Evaluate Deleted Services	**EDS** Send HCE spreadsheets for deleted codes Description of Deleted Codes • This spreadsheet contains the Procedure Code, Short Description, EOMB Description, Long Description, Recommended Replacement Codes, Procedure Add Date, Procedure Effective Date, and Procedure Termination Date Deleted Codes on Limitation Audits • This spreadsheet contains the Procedure Code, Short Description, Procedure From, Procedure To, Modifier, Audit Code, Audit Description, Allow CCF Indicator, Allow Deny Indicator, Allow Override Indicator, Cost Containment Indicator, Header/Detail Indicator, and Claim Location Deleted Codes on Non-Limitation Audits • This spreadsheet contains the Procedure Code, Short Description, Current Procedure From, Current Procedure To, Current Modifier, History Procedure From, History Procedure To, History Modifier, Audit Code, Audit Description, Allow CCF Indicator, Allow Deny Indicator, Allow Override Indicator, Cost Containment Indicator, Header/Detail Indicator, and Claim Location Deleted Codes on Procedure Groups **and MAR Procedure Groups** • This spreadsheet contains the Procedure Code, Short Description, Table Number, Table Description, Effective Date, and End Date Replacement Codes on Tables • This spreadsheet contains the Procedure Code, Short Description, Table Number, Table Description, Effective Date, and End Date

TABLE III–11: HCPCS BUSINESS PROCESS
(continued)

Process	Description
Evaluated Deleted Services (continued)	Deleted Codes That Require PA • This spreadsheet contains the Procedure Code, Program, Effective Date, End Date, Diagnosis Indicator, Place Of Service Indicator, Specialty Indicator, and Age Indicator Deleted Codes with Active PA Line Items • This spreadsheet contains the PA Number, Procedure Code, PA Line Item Number, Request Effective Date, Request End Date, Authorized Effective Date, Authorized End Date, and Status Code Deleted Codes that have PICs associated with them • This spreadsheet contains the Procedure Code, Modifiers, Taxonomy, and Short Description of the PIC code Description of Deleted Modifiers • This spreadsheet contains the Modifier Code, Short Description, Long Description, Recommended Replacement Modifiers, Effective Date, and Termination Date Procedures that have Deleted Modifiers attached • This spreadsheet contains the Procedure Code, Procedure Short Description, and Deleted Modifier Code(s) **HCE** Deleted code is non-covered • End-date the code, no replacement code is necessary

TABLE III–11: HCPCS BUSINESS PROCESS
(continued)

Process	Description
Evaluated Deleted Services (continued)	Deleted code is covered • Replacement code is a new appropriate replacement code System will update the deleted code with the replacement code • Replacement code is an existing covered code Review pricing from the deleted code to the replacement code • Replacement code is an existing non-covered code Cover the replacement code if appropriate • Replacement code is not an appropriate replacement Find an appropriate replacement code • No replacement code Review how the service should be covered, find an appropriate replacement code • Review if the service should still be covered Review PICs using the same steps Review deleted modifiers • In relation to PIC codes • Assess modifier type (pricing, processing, information, anesthesia, etc.) Send to EDS and the State for review
Evaluate Pricing	**EDS** will download pricing for each of the following: EDS gathers Indiana RVU pricing from the Medicare Fee Schedule, and DMERC and CLIA Lab pricing from Medicare website. EDS loads pricing for all new services on the file. Those new services that do not have RVU pricing are loaded into AIM with a default pricing indicator of RBRVS and a default price of zero, and are identified for further review.

TABLE III–11: HCPCS BUSINESS PROCESS
(continued)

Process	Description
Evaluate Pricing (continued)	**EDS** will perform the tasks listed below to find appropriate pricing. • Load Anesthesia RVUs for all new ASA codes • Load all rates associated with new Dental Codes from the ADA file • Identify a benchmark NDC for all new J/ Q and immunization codes and use the AWP rate on file for the NDC as the new rate • Download the ASC assignments for all new surgical codes. For codes that do not have an assigned ASC, send to HCE for assignment • Send a list of all new radiology codes to Myers and Stauffer for the outpatient max fee (TC) rate
Review Service Recommendations	**HCE** Initial review • Codes will be sent to OMPP to review new services and technology • Round Table to review coverage – OMPP, HCE, EDS, Waiver, Managed Care Send OMPP the final recommendations for add and delete codes
Approve Service Recommendations	**HCE** Send OMPP the final code recommendations for approval
System Updates	**EDS** Load Access database sheets with HCE code review information **HCE** Check the system and make necessary corrections to code reviews or the system
Provider Notifications	**HCE** will prepare a banners/bulletins/newsletters

TABLE III-12: HCPCS WORKPLAN

PHASE I - PREPARATION			
Description	**Responsible Contractor**	**Initiate Task**	**Complete Task**
Inventory, assess and order resources, as applicable.	HCE/EDS		
Review all Web sites and CMS publish dates.	HCE/EDS/ M&S		
Review and approve the Access database.	HCE		
Review and approve the HCPCS workplan.	HCE/EDS/ OMPP		
Develop and approve the HCPCS bulletin template.	HCE/EDS/ OMPP		
The HCE HCPCS Project Coordinator and EDS HCPCS Project Leader will develop training materials, and conduct training for involved departments and staff.	HCE/EDS		
Order the Anesthesia RVU manual from the ASA. RVUs for the new code publications are available in March.	HCE		

TABLE III-12: HCPCS WORKPLAN
(continued)

PHASE II – ASSIGNMENTS/REVIEW			
Description	**Responsible Contractor**	**Initiate Task**	**Complete Task**
Receive annual HCPCS updates from CMS. Notify OMPP and HCE if the tape is delayed.	EDS		
Download code updates into an Excel spreadsheet.	EDS		
EDS will forward Excel spreadsheets to HCE Medical Policy Director and HCPCS Project Leader: Deleted Codes Current edits, audits and tables for deleted codes Deleted codes on PA Deleted codes that reference a PA Replacement code list Current combination codes ({PIC) in the system New code and modifier updates with pricing from fee schedules (physician, DME, lab, anesthesia RVU) Descriptions that are too long D codes with minimum age requirements Active edit and audit code list Add codes that are already in the system (codes that are being reused by CMS) Codes with ICIC indicated Current procedure group list	EDS		
Convert the EDS Excel spreadsheet into the Access database for code reviews.	HCE		
Assign and distribute HCPCS codes to Medical Policy Specialists assigned to the project for review.	HCE		
Review deleted CPT and HCPCS codes and replacements.	HCE		
Begin development of the November provider bulletin. This bulletin will include deleted codes with replacements.	HCE		
Notify Waiver of new codes and combination code changes.	HCE		

TABLE III-12: HCPCS WORKPLAN (continued)

PHASE II – ASSIGNMENTS/REVIEW (continued)			
Description	**Responsible Contractor**	**Initiate Task**	**Complete Task**
Revise the draft bulletin and send through HCE document integrity in MP, and all departments.	HCE		
Send draft bulletin to EDS, M&S, and OMPP for final review.	HCE/EDS/ M&S/OMPP		
Review new and changed CPT and HCPCS codes.	HCE		
Review: Description accuracy and length Coverage - IAC Limits and Restrictions Prior Authorization Requirements Audits/Edits/Procedure Groups FQHC/RHC 155/6096 Nursing Home Per Diem 141 MAR Procedure Groups Modifiers DME RR, NU Lab and Radiology TC, 26 CPT versus HCPCS Code (G codes) Comprehensive and Global Codes	HCE/EDS		
EDS will pull and load manually priced lab codes.	EDS		
Myers and Stauffer and EDS coordinate outpatient radiology fees.	EDS/ M&S		
Download physician, DME, lab, and ASC fee schedule information into the Excel spreadsheet. EDS will append the AS modifier to all codes that have the 80, 81, and 82 modifier.	EDS		
Forward the deleted code bulletin to EDS for publication November 15.	HCE		
Hold internal meetings at HCE (PA, SUR, Medical Director) and EDS.	HCE		
Coverage Round Table at OMPP to review code coverage and/or pricing issues.	EDS/HCE/ M&S/OMPP		
Send coverage issue codes to consultants.	HCE		

TABLE III-12: HCPCS WORKPLAN (continued)

PHASE II – ASSIGNMENTS/REVIEW (continued)			
Description	**Responsible Contractor**	**Initiate Task**	**Complete Task**
Begin development of the December provider bulletin. This bulletin will include add codes and changed codes.	HCE		
Update the Access database information. All reviews and comments will be compiled into the database and bulletin.	HCE		
Revise the draft bulletin and send through HCE document integrity in MP, and all departments.	HCE		
Meet at EDS to discuss edits, audits, procedure groups, and pricing.	HCE/EDS/ OMPP		
Send draft bulletin to EDS, M&S and OMPP for final review.	HCE/EDS/ M&S/OMPP		
Review pricing, pricing indicators. Transportation codes must have transportation indicator.	EDS		
Correct or update the spreadsheet after issues are discussed and resolved.	HCE		
Forward completed copy of the bulletin to EDS for publication December 23.	HCE		
Forward the RCO and a hardcopy of the Access database sheets to EDS.	HCE		

TABLE III-12: HCPCS WORKPLAN
(continued)

PHASE III –SYSTEM IMPLEMENTATION			
Description	**Responsible Contractor**	**Initiate Task**	**Complete Task**
Load code information from the Access database sheets in Indiana*AIM*.	EDS		
Review system for completion of new codes.	HCE/EDS		
Send EDS notification of any corrections needed.	HCE		
If corrections are needed from HCE, HCE will complete an RCO and publish provider notification.	HCE		
Review the HCPCS process and implement a new workplan.	HCE/EDS/ M&S/OMPP		
Obtain and Load latest ASC rates from the CMS Web site.	EDS		
Close the HCPCS Annual Update project.	HCE		

M. Annual ICD-9-CM Update Coordination

Changes are made annually to ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) codes. OMPP, EDS and the HCE MP department coordinate the implementation of these changes to the Indiana*AIM* system. **(Refer to Table III-13.)**

TABLE III-13: ANNUAL ICD-9-CM UPDATE COORDINATION

No.	Responsible Person/Contractor	Procedure
1	EDS System	Obtains new codes, enters the codes into the Indiana*AIM* system. EDS tests any necessary system modifications, and HCE and OMPP review the results.
2	EDS	Conducts a planning meeting with OMPP and HCE to discuss implementation of the ICD-9-CM codes.
3	EDS System	Produces a report listing the new codes.
4	EDS System	Sends a copy of the report to the HCE MP department.
5	HCE MP Department	Reviews the report and makes necessary recommendations.
6	HCE MP Department	Forwards a copy of the recommendations to OMPP for review and approval.
7	HCE MP Department	Communicates the recommendations to EDS after OMPP approval.
8	EDS System	Implements the recommendations made by HCE.
9	EDS System	Informs HCE that the recommendations have been applied.
10	HCE MP Staff	Reviews the system changes to ensure the appropriate changes were made.
11	HCE MP Staff	Prepares a banner or provider newsletter article describing the changes made, and forwards the banner or provider newsletter article to EDS for publication. (Follows General Coordination Document Management Coordination GC–3.4.)
12	EDS	Installation of mapping software is complete.

N. Application Process for New HCPCS Codes

New HCPCS codes are sometimes needed to represent new medical procedures, technology, etc. The process of applying for a new HCPCS code is outlined below.

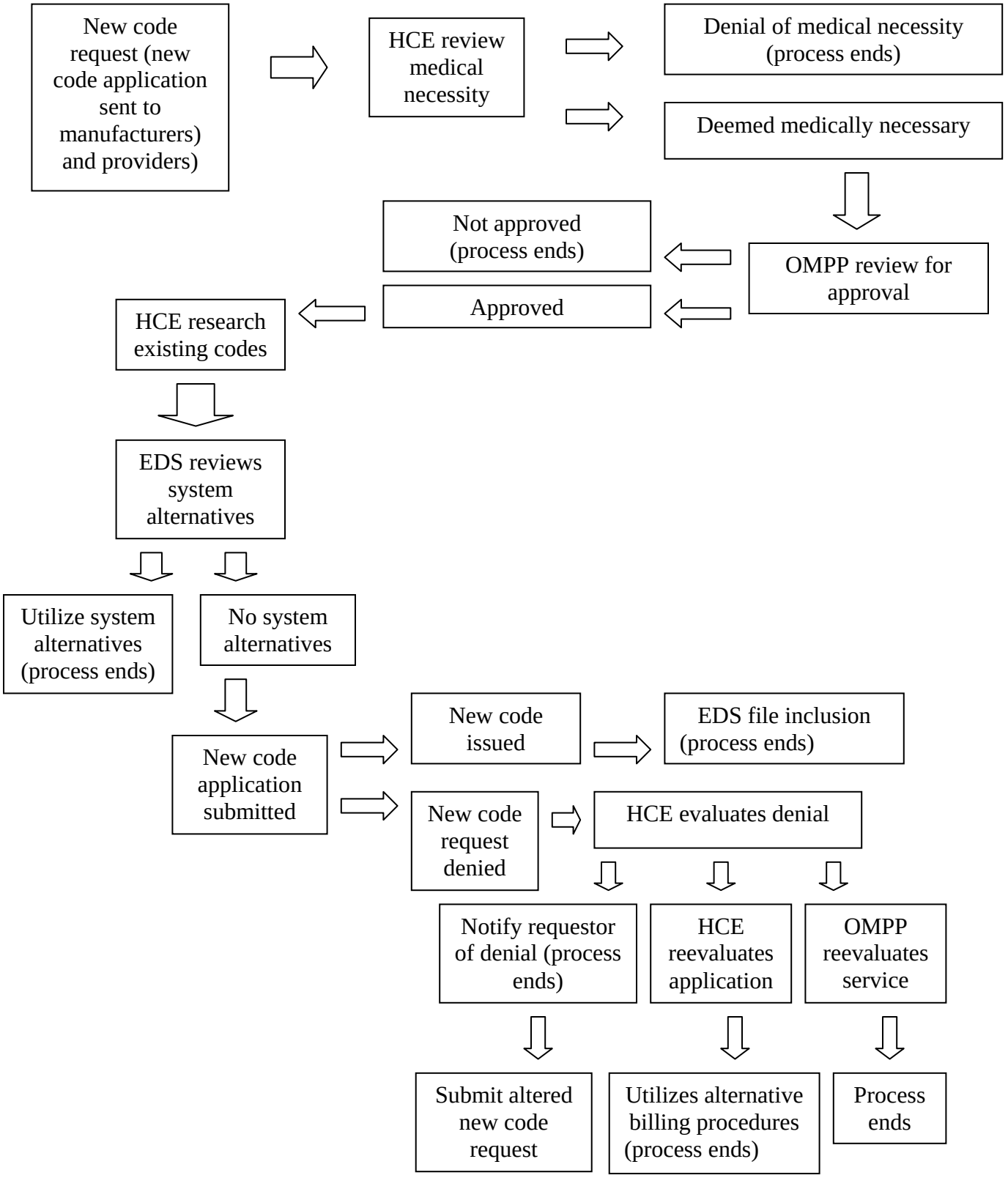
TABLE III-14: NEW HCPCS CODE REQUEST

No.	Description of Activity	Responsible Party
1	Code request is presented to HCE. ♦ Provider and manufacturer requests ♦ Program (HCE, OMPP, Waiver, Other) requests proceed to step 4	Requestor
2	Send provider/manufacturer new code application.	MPS
3	Provider/manufacturer completes new code application and returns it to HCE.	Provider/Manufacturer
4	HCE evaluates code request for medical necessity. ♦ Services deemed medically necessary ♦ Notify requestor of services not deemed medically necessary and the process ends	MPS/MD/PD
5	HCE forwards request to OMPP for approval.	MPS
6	OMPP reviews the request and notifies HCE of decision.	OMPP
7	OMPP approves request. Notify requestor of code if not approved. Process ends.	MPS
8	HCE review and coordination. ♦ Review of current codes ♦ Review of applicability of pricing segments ♦ Evaluate current code that could be used in combination with a modifier ♦ Review the web site for recent code updates If applicable code is available proceed to step 14.	MPS
9	Refer to EDS for possible system alternatives. If applicable code is available proceed to step 14 .	MPS EDS

TABLE III-14: NEW HCPCS CODE REQUEST (Continued)

No.	Description of Activity	Responsible Party
10	EDS contacts HCE with system alternative findings. HCE evaluates any alternative findings. No alternative finding proceed to step 11.	EDS/MPS
11	MP unit initiates application for national code and notifies the initiator.	MPS
12	HCE MP to maintain correspondence on acceptance or denial of application and forwards the information to the initiator. If new code is issued proceed to step 14	MPS
13	The code application is denied. • HCE evaluates denial • HCE researches existing codes • OMPP reevaluates service need • OMPP researches alternate billing procedure	MPS/OMPP
14	Information forwarded to EDS reference file for inclusion.	MPS

NEW HCPCS CODE REQUEST



O. Subscriptions and Sources of Information

There are numerous subscriptions and sources of information to support the formulation, maintenance, and communication of medical policy. A sample of sources has been listed below.

- American Society of Anesthesiologists (ASA)
- CCH Incorporated
- CDT-5
- Centers for Disease Control Statistics and Reports
- Clinical Practice Guidelines - AHCPR, AMA
- CMS's Laws, Regulations, and Manuals
- Code of Federal Regulations
- Complaint Tracking Report
- CPT Assistant
- CPT-4 Coding
- DME transmittals and bulletins
- EPIC Plus software
- Federal Register
- Flash Code
- HCPCS
- Health Policy Tracking Service
- Healthcare Trends Report
- ICD-9-CM
- Indiana Administrative Code
- Indiana Register
- Indiana*AIM* manuals
- MP Committee meetings
- Medical Policy reports and projects
- Medical Utilization Management
- Medicare and Medicaid Guide
- Medicare FI and Carrier transmittals
- National Library of Medicine
- PA reports and projects
- Provider Bulletins, Banner Pages and Provider Newsletter Articles
- Provider Manuals
- RBMC reports and committee meeting minutes
- State Health Watch
- SUR reports and projects
- The Digest of Health Care for the Poor and Disabled
- The Quality Letter for Healthcare Leaders
- UB-92 Editor

IV. REPORTS

A. Medical Policy Monthly Workplan and Activities Report
B. Semiannual Report
C. Psychiatric Residential Treatment Facilities (PRTF)

A. MEDICAL POLICY MONTHLY WORKPLAN AND ACTIVITIES REPORT

MEDICAL POLICY MONTHLY WORKPLAN/ACTIVITIES REPORT
(enter month/year through month/year)

EXPLANATION OF WORKPLAN/ACTIVITIES REPORT

The Medical Policy Workplan and Activities Report is designed to delineate ongoing activities and special projects, quality improvement, and cost-containment reporting in compliance with MPC-8, 9, and 39 listed in RFP 3-45. This report includes Medical Policy activities for the month of (enter month and year).

MEDICAL POLICY REPORTING REQUIREMENTS
MONTHLY REPORT GROUPING

Updated work plan for special projects and ongoing activities

Section 1.0 Projects

This section delineates all projects, including the resources assigned, the scheduled completion date, the status of the research, and the priority ranking. It includes current research projects, State approved projects in coordination with EDS or OMPP, and projects for utilization review.

Projects are defined as the research and development of new Medicaid policies, the evaluation and recommended revisions for existing policies, or as the formal request for specific information requiring research. Projects may be presented to the Medical Policy Committee for final approval. Priority ranking is determined using the following scale and considerations.

Priority Scale	Estimated Completion
1 Expedite	completion in less than 1 month
2 Immediate	completion in 1 to 3 months
3 Intermediate	completion in 4 to 8 months
4 Long Term	completion in more than 8 months
5 Ongoing	completion in ongoing cycles throughout the year

Priority variables

Directives from OMPP
Current legislation and rule promulgation
Consideration of political atmosphere
Medical necessity of issue
Quality of care
Cost containment

OMPP will be consulted in the balancing of priorities with available resources.

Section 2.0 Completed Projects

This section lists projects that have been completed by Health Care Excel (HCE) during the current year.

Section 3.0 Reference File

This section summarizes the Reference File requests sent to EDS from HCE that are still pending and those that have been completed during the reporting month.

SECTION 1.0 TASK 1: Current Research Projects					
Task Name	**Source of Issue**	**Assigned Medical Policy Staff**	**Target Completion Date**	**Objectives /Comments/ Status/ Recommendations**	**Priority Ranking**

SECTION 1.0 TASK 2: Provider Code Sets					
Task Name	**Source of Issue**	**Assigned Medical Policy Staff**	**Target Implementation Date**	**Objectives /Comments/ Status/ Recommendations**	**Priority Ranking**

SECTION 1.0 TASK 3: 2004 HCPCS Update Generated Projects					
Task Name	**Source of Issue**	**Assigned Medical Policy Staff**	**Target Completion Date**	**Objectives /Comments/ Status/ Recommendations**	**Priority Ranking**

SECTION 1.0 TASK 4: Manufacturer/Provider Initiated Projects					
Task Name	**Source of Issue**	**Assigned Medical Policy Staff**	**Target Completion Date**	**Objectives /Comments/ Status/ Recommendations**	**Priority Ranking**

SECTION 1.0 TASK 5: Utilization Review Projects			
Task Name	**Assigned Medical Policy Staff**	**Scheduled Review Date**	**Objectives /Comments/ Status/ Recommendations**

SECTION 1.0 TASK 5: System Correction Review		
Task Name	**Scheduled Finish Date**	**Objectives /Comments/ Status/ Recommendations**

SECTION 2.0 Completed Projects		
Task Name	**Completion Date**	**Comments**

Section 3.0 Indiana*AIM* Reference File

The grid below identifies Reference Change Orders, Research Service Requests, Customer Service Requests, and Change Orders (RCOs, RSRs, CSRs, and COs) currently in coordination between MP and EDS.

Date Sent to EDS	HCE Tracking Number	Description	Status

Note: The source of information for completed RCOs/RSRs is through query of the HCE master log. Completed items will be

B. SEMIANNUAL REPORT

MEDICAL POLICY SEMIANNUAL REPORT
(enter dates)

Table of Contents

I. Executive Summary

This section will provide a summary of the recommendations from the Medical Policy department.

II. Report Requirements

This section documents the contract requirements for preparing, distributing and presenting this report.

III. Expenditure and Membership Trends

Reporting in this section include data and fiscal information obtained and analyzed, the specific trends identified, total expenditures involved (including charts when applicable), and recommendations.

IV. Medical Policy Trends

This section identifies all trends specific to the Medical Policy department.

V. Medical Policy Manual

This section lists the areas of the Medical Policy Manual under review for the year, with modification that may be appropriate, based upon the trend analysis.

VI. Recommendations

This section will provide a summary of the recommendations from the Medical Policy department, based upon the total program trends.

C. PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTF)

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES REPORT (PRTF)

2004 Paid Claims Statistics

	OMPP Projection[1]	January-March[2]	April	May	June	July	August	September[6]	YTD Total
Per Diem PRTF Expenditures[3]									
Non-Per Diem Expenditures[3]									
Pharmacy Services[3]									
Members[3]									
Days of Care[3]									
Therapeutic Leave Days									
Medical Leave Days									
Enrolled Providers									
Participating Providers									
PRTF Admissions[3]									
PRTF Discharges[3]									
Average Length of Stay									

Explanatory Footnotes:

1. Baseline comparisons include projected 25% increase anticipated by Indiana FSSA's Division of Family & Children.
2. Delayed approval of State Plan resulted in February implementation retroactive to 1/1/04 effective date.
3. Based on paid claims. Non-Per Diem claims for September include $26 for services performed while the member was on therapeutic leave.
4. Member admissions often last more than one month, therefore, the year to date total of members is not the sum of the members served each month.
5. This statistic is based on the members discharged with paid claims in June through September of 2004.
6. Members with no PRTF claims prior to September 2004 represent $1,071,495 or 69% of per diem expenses, $17,351 or 62% of non-per diem expenses, $80,016 or 78% of pharmacy expenses and 3,379 or 69% of days of care.

.

2004 PA Statistics

	OMPP Projection[1]	January-March[2]	April	May	June	July	August	September	YTD Total
Total PAs Requested[3]									
PAs Requested New Admissions[3]									
PAs Requested Concurrent Reviews[3]									
PCCM PAs Requested[3]									
RBMC PAs Requested[3]									
PAs Approved[3]									
PAs Denied[3]									
PAs Modified[3]									
PAs Suspended[3]									

Explanatory Footnotes:

1. Baseline comparisons include projected 25% increase anticipated by Indiana FSSA's Division of Family & Children.
2. Delayed approval of State Plan resulted in February implementation retroactive to 1/1/04 effective date.
3. PA information is based on PAs processed by the PA department. Because of the time lag between PA approval and subsequent payment of the claim, as well as the retroactive PAs allowed at inception of the program, the number of admissions and claims will not appear to match the number of PAs.
4. Not Available
5. YTD Total includes

Non-Per Diem Claims Paid Through (enter date)

Member ID	Non-Per Diem Provider ID	Non-Per Diem Provider Name	No. of Claim Details	Amount Paid
Member Total				

PRTF Inpatient Admissions
Comparison of Medical Leave Days in Excess of 4 to Inpatient Hospital Days
Through (enter date)

Enrolled PRTF Provider	Dates of Medical Leave	No. of Medical Leave Days	No. of Inpatient Hospital Days	Variance

Cumulative Therapeutic Leave Days for the Calendar Year
Through (enter date)

Provider ID

Provider	Cumulative Therapeutic Leave Days
Total Facility	

V. SAMPLE FORMS

A. Medical Policy Inquiries

B. Medical Policy Inquiry Intake Form

C. Request for Review by Medical Director or Consultant

D. Internal Referrals

E. Medical Policy Committee Report

F. Medical Policy Administrative Report Summary

G. Medical Policy Fact Sheet

H. Letter to Requestor

I. Data Request Form

J. Document Transmittal Form

K. Request for Information-Survey Form

L. Request for IHCP Coverage of a DME Technology-Form and Letter

M. Request for Medical Policy Project Research

A. MEDICAL POLICY INQUIRIES

Goal: Provide guidelines for information that needs to be captured to research and respond to inquiries received in the Medical Policy Department. Based on the inquiry, some of these items may not be applicable.

INQUIRER'S NAME:_____ PHONE NUMBER W/ AREA CODE:_____

ORGANIZATION:_____

CLAIMS: PROVIDER NUMBER (9 DIGITS/ALPHA):_____

INTERNAL CONTROL NUMBER (ICN) (13 DIGITS):_____ DATE OF SERVICE:_____

EXPLANATION OF BENEFIT (EOB) MESSAGE:_____

If applicable: RECIPIENT IDENTIFICATION NUMBER (12 DIGITS):_____

If there are multiple claims, you may want to ask them to FAX the information to us at (317) 347-4573.

PRICING INQUIRIES: PROCEDURE CODE:_____ MODIFIERS (If any):_____

DRUG INQUIRIES: NATIONAL DRUG CODE (NDC) (11 DIGITS):_____

If the caller indicates they are following instructions from OMPP, EDS or HCE, get the following information:

Provider Manual: DATE OF MANUAL:_____ SECTION AND PAGE NUMBER_____
Bulletin: BULLETIN NUMBER:_____
Banner page: DATE OF RECEIPT:_____
An individual: PERSON'S NAME:_____COMPANY:_____

INSTRUCTIONS RECEIVED:_____

DATE INSTRUCTIONS RECEIVED:_____

NATURE OF CALL:_____

_____

_____

_____

RESOLUTION:_____

_____

_____

_____Date Resolved_____

A. MEDICAL POLICY INQUIRIES (Continued)

REMEMBER THAT THE MORE INFORMATION YOU CAN RETRIEVE FROM THE PERSON MAKING THE INQUIRY, THE EASIER IT WILL BE TO RESPOND APPROPRIATELY.

DATE INQUIRY RECEIVED_____ SPECIALIST_____

INSTRUCTIONS FOR COMPLETING THE MEDICAL POLICY INQUIRIES FORM

1. Enter the name of the person making the inquiry.
2. Enter the telephone number of the person making the inquiry. Include the area code if long distance.
3. Enter the organization or provider for whom the person making the inquiry is associated.
4. Enter the provider number if applicable.
   If the inquiry involves a specific claim, complete number 5 - 8.
5. Enter the 13 digit internal control number.
6. Enter the date of service (the date the service in question was rendered).
7. Enter the 4 digit explanation of benefit message number if applicable.
8. Enter the 12 digit member identification number if applicable.
   If the inquiry concerns a pricing question, complete numbers 9 and 10.
9. Enter the procedure code, if known, for the service or product in question.
10. Enter any modifiers that are applicable.
11. **If the inquiry concerns a drug or pharmaceutical item**, enter the 11 digit national drug code (NDC).
    If the inquiry concerns previously received instructions -written or oral, complete numbers 12 - 19.
12. If the information was found in the Provider Manual, enter the date of the manual
13. Enter the Section and Page number(s) where the information can be found in the Manual.
14. If the information was found in a Provider Update Bulletin, enter the bulletin number.
15. If the information was found in a Banner message, enter the date of the banner.
16. If the information was received from an individual, enter the person's name.
17. Enter the name of the company for whom the person giving the information is associated.
18. Note the information/instructions received.
19. Enter the date the information/instructions was received.
20. Enter information concerning the nature of the call (i.e., what was the inquiry - be specific).
21. Enter the resolution of the inquiry, including the date resolved and the date the inquirer was notified.
22. Enter the date the inquiry was received.
23. Enter the name of the Medical Policy Specialist.

NOTE: Attach additional pages if necessary to fully describe the nature of the call and the resolution of the inquiry. Attach any research information.

B. MEDICAL POLICY TELEPHONE INQUIRY INTAKE FORM

Health Care Excel
Indiana Medical Policy and Review Services
Medical Policy Inquiry Intake Form

Date _____ **Assigned To** _____

Name _____ **Organization** _____

Phone Number _____ **Provider #** _____

Inquiry _____

_____

_____

_____

_____

Date _____ **Assigned To** _____

Name _____ **Organization** _____

Phone Number _____ **Provider #** _____

Inquiry _____

_____

_____

_____

_____

Date _____ **Assigned To** _____

Name _____ **Organization** _____

Phone Number _____ **Provider #** _____

Inquiry _____

_____

_____

_____

INSTRUCTIONS FOR COMPLETING THE MEDICAL POLICY TELEPHONE INQUIRY INTAKE FORM

1. Enter the date of the inquiry.
2. Enter the name of the person calling in the inquiry.
3. Enter the organization or provider for whom the person making the inquiry is associated.
4. Enter the phone number of the inquirer.
5. Enter the provider number of the inquirer.
6. Enter the specifics of the inquiry. If the call is a live call, try to get as much information as possible. If the inquiry is a message from voice mail, enter all relevant information from the message.

C. REQUEST FOR REVIEW BY MEDICAL DIRECTOR OR CONSULTANT

Health Care Excel
Indiana Medical Policy and Review Services
Request for Review by Medical Director or Consultant

☐ **Project** ☐ **Inquiry**

Project Tracking #: _____

To: _____ **DATE DUE:** _____

From: _____ **DATE DELIVERED:** _____

Review of the attached Inquiry or Project for the following reason (s):

Please review the attached documentation, render your comment (s) below, and return this completed form to the Medical Policy Specialist listed above:

Medical Reviewer(s) Comment(s):

_____ _____
Medical Director **Date**

_____ _____
Medical Consultant **Date**

Date returned to the Medical Policy Specialist: _____

INSTRUCTIONS FOR COMPLETING REQUEST FOR REVIEW BY MEDICAL DIRECTOR OR CONSULTANT FORM

This form should be completed for each project for the Medical Policy department in the following manner:

1. If requesting medical review of a project or inquiry, place an x in the box next to the appropriate title. If the item has a tracking number, place the tracking number in the box as indicated.

2. The Medical Policy Specialist should make the "Date Due," at a minimum, seven days after the "DATE DELIVERED" to the Medical Director.

3. The Medical Policy Specialist should place his/her name on the "From" line.

4. The Medical Policy Specialist should place the date the request was sent to the Medical Director on the "DATE DELIVERED" line.

5. The Medical Policy Specialist should make a copy of the Medical Review Form to be maintained by the Specialist for tracking. The original Medical Review Form shall be forwarded with the report to the Medical Director.

6. The medical reviewer may be the Medical Director or an HCE consultant. The medical reviewer must complete the "Medical Reviewer(s) Comment(s)" section with a recommendation on coverage, medical necessity, or other comment in regards to the service or item.

7. The medical reviewer must sign and date the medical review form as indicated.

8. The Medical Specialist shall document the date the request was returned to him or her at the bottom of the page as indicated.

9. If the Medical Review Form is not returned within seven days, a notation should be made on the copy maintained by the Specialist and sent to the Medical Policy Director for further guidance.

D. INTERNAL REFERRAL FORM

Health Care Excel
Indiana Medical Policy and Review Services
Internal Referral

Reported by External Source ☐ Internal Source ☐

Need to discuss with MP Specialist prior to research starting. ☐

Response to be sent to:

Response needed by: (An initial response will be made by Medical Policy within the 10-day time frame.)

Response to be copied by:

Internal:

Name of reporting Department Director/Supervisor:

Director/Supervisor Approval:

Telephone/Extension:

Date of Referral:

Initial Referral Reported by:

Date:

Prior Authorization #: (as needed)

Recipient #: (as needed)

ICN #: (as needed)

External (provider, provider association):

Name of Concerned Party:

Date:

Address of Concerned Party:

City: State: Zip:

Telephone:

D. INTERNAL REFERRAL TO MEDICAL POLICY DEPARTMENT (continued)

Health Care Excel
Indiana Medical Policy and Review Services
Internal Referral

Issue (clear, concise description of the question to be answered):

Intended use of response (recoupment, association meeting, educational):

Qualifying details related to the questions, such as examples of claims:

List and quote all references that you have already reviewed, such as law, provider manual, or bulletin:

E. MEDICAL POLICY COMMITTEE REPORT

MP Specialist/Research Specialist:

Tracking #:

Project Name:

Date: **Status:**

ISSUE:

Give a concise but comprehensive description of the issue, including the history of the issue (how/where/why the issue arose). What goal are we trying to accomplish?

SERVICE:

Name of service

DESCRIPTION OF SERVICE:

Short description of what service is.

Is service comprised of single entity, or components? If components, specify what the components are and address each component separately for applicable factors listed below.

CURRENT COVERAGE STATUS IN INDIANA:

Is the service currently covered by Indiana Medicaid? Type in Yes. or No.

Specify the rule or policy that substantiates current coverage.

Have claims been paid for the service? Type in Yes. or No.

If yes, indicate the following:

Starting when, how many claims, total amount reimbursed to date, under what codes.

What are the current standards of local practice?

Has Prior Authorization been given for the service? Type in Yes. or No.

E. MEDICAL POLICY COMMITTEE REPORT (Continued)

If yes, explain.

CURRENT STATUS BY OTHER APPROVING BODIES

Is service subject to approval by an approving/regulatory body? Type in Yes. or No.

If so, has the service been approved and by whom? What is the date of approval?

Is provision of the service restricted by practice act or other law to only certain types of providers? Type in Yes. or No.

If so, specify which, and indicate any applicable limitations.

CURRENT COVERAGE STATUS BY MEDICARE/OTHER PAYORS

Is the service currently covered by Medicare? Type in Yes. or No.

If so, state effective date of coverage, criteria for payment of this service, service limitations/restrictions, provider types rendering service, and coding parameters.

Is the service currently covered by other payors? Type in Yes. or No.

If so, state which payor, effective date of coverage, criteria for payment of this service, service limitations/restrictions, provider types rendering service, and coding parameters.

CURRENT COVERAGE STATUS BY OTHER MEDICAID PROGRAMS

Is the service currently covered by other state Medicaid programs? Type in Yes. or No.

Include summary of review of other states, their coverage policy including limitations, restrictions, coding parameters, effective date of coverage/non-coverage, payment policies, etc.

FRAUD AND ABUSE INFORMATION

What is the risk of, or likelihood for, abuse/misutilization of this service?

If significant, what does HCE suggest in order to minimize or obviate the abuse/misutilization?

RECOMMENDATIONS:

Is coverage of this service recommended? Type in Yes. or No.

Briefly state rationale for coverage/non-coverage recommendation.

E. MEDICAL POLICY COMMITTEE REPORT (Continued)

Is rule promulgation required? Type in Yes. or No.

Briefly state why rule promulgation is/isn't required.

If recommending coverage, specify the following:

Effective date.

Should prior authorization be required? If so, what the medical necessity rule criteria should be used?

If prior authorization is not required, are front-end edits needed? If so, specify what types and how to be applied. If not, are post-payment controls needed? If so, specify types, nature of the controls and how often applied.

What service coverage and limitations should be applied?

Which provider types would be providing/billing the service?

Suggested reimbursement level.

Coding.

Is provider notification of coverage/non-coverage required? Is so, provide suggested text.

Other topic-related comments, observations, suggestions, or recommendations by HCE.

NEXT STEPS:

List tasks to complete project.

IMPACT ANALYSIS SUMMARY:

Fiscal impact should take into consideration all factors in the recommendation section.

All data obtained by the statistician, should be analyzed by the statistician and explained in narratives for each table constructed.

E. MEDICAL POLICY COMMITTEE REPORT (Continued)

RESEARCH SUMMARY:

All summarized research should be pertinent to the issue and support the recommendations you are making. This section should summarize the research completed that is not included in the previous sections of this report.

F. MEDICAL POLICY ADMINISTRATIVE REPORT SUMMARY

Medical Policy Administrative Report

MP Specialist/Research Specialist:

Project Name:

Scheduled Due Date:

Current Date: *The date the report is printed should be documented in order to track drafts.*

Status: *List the draft number for documentation purposes.*

ISSUE
State the reason the report is being written/why OMPP requested the report.
A second paragraph can state what topics will be discussed in the paper if the GOALS section is not utilized.

EXECUTIVE SUMMARY
Synopsis of the issues researched, findings and recommendations.

GOALS (OPTIONAL)
Numeric list of goals.

[BODY]
The body should include titled topics based on the individual report being presented. MP reports usually include titles such as Overview, Definitions, IHCP Coverage, Medicare Coverage Criteria, Region V Coverage Criteria, Prior Authorization Criteria, Coding and Reimbursement, Fiscal Analysis, etc. The body of the report is usually, but not always, formatted in this general order. Not all categories are used in every paper.

Body Titles can haves subtitles that should be bold, but should not be underlined.

DISCUSSION (OPTIONAL)
Some larger and more complicated reports require a summary and discussion of the material presented. Other reports require conclusions to be drawn or decisions to be made about the project that is not considered a recommendation. In some reports the discussion and recommendations will be combined.

RECOMMENDATIONS
Recommendations can be in paragraph form, a numeric list, a bulleted list or a combination. Caution should be given to recommend and not tell the OMPP what steps to take.

NEXT STEPS
Next steps are usually presented as a numeric list.

G. MEDICAL POLICY FACT SHEET

MEDICAL POLICY FACT SHEET

TITLE

DESCRIPTION

Brief description of service. Format should be justified, Times New Roman, 12 point. There should be a triple space between the major subject areas and subject area title should be bold and capitals.

COVERAGE CRITERIA

Description of coverage

Example of a table format is as follows. If a table carries to the next page, the Title row and the header columns should be carried over.

Table 1 – Title

Column Header	Column Header	Column Header	Column Header
Information should be centered vertically	Numbers, such as CPT codes should be centered horizontally i.e 112345	Row content should not be split between pages	

Subheadings
Subheadings should have a double space above and then single space to text, such as is demonstrated here.

PRIOR AUTHORIZATION

1. Criteria that has been approved for use in the Prior Authorization process
2. Notation of services that require Prior Authorization

MANAGED CARE

Information specific to PrimeStep, Hoosier Healthwise packages, MCO's

G. MEDICAL POLICY FACT SHEET (Continued)

BILLING REQUIREMENTS

Noteworthy billing requirements that are specific to this service
This is not intended to spell out the entire billing process.

RELATED MEDICAL TOPICS

A list of other fact sheets that may provide related information to the services described in this fact sheet.

RULES, CITATIONS, AND SOURCES

List of all CFR, IC & IAC Citations, including subject of citations (List Numerically)
Other Sources of information (banners, bulletins, newsletters, etc.) - List by Source then give subject of notification, i.e.

Indiana Health Coverage Programs Provider Newsletters
NL2005XX – Physician Services
Indiana Health Coverage Programs Provider Bulletins
BT2005XX – Billing Requirements for XXXXXXXXXXXXXX
BT2005XX – Changes in Prior Authorization

Origination Date: Date Fact Sheet originally approved for MP Manual

Revisions and Review	Reason	Date
Revision	Changes in Billing Requirements	Date of policy change
Revision	Changes in Prior Authorization	Date of policy change
Review	Scheduled	Date of Quarter Review such as MM/DD/YY

APPLICABLE INDIANA*AIM* EDITS AND AUDITS

Numeric list of all edit and audits for this service – Title of edit/audit

H. LETTER TO REQUESTOR

(*Date*)

(*Name & Address*)

Re: (*Medical Policy Issue or Request*)

Dear (*Name of Requestor*):

Your request for information concerning (*Medical Policy Issue*) was received in this office today, (*Date*). Upon completion of the necessary research, we will notify you of the findings and decision. If additional documentation is required, we may write or call you for assistance. Please feel free to call me if you have further questions.

Thank you for your consideration in this matter.

Sincerely,

(*Medical Policy Director's Name*)
Director, Medical Policy
(317) 347-4500, Ext. 275

Topic_____ **Requestor** _____
Date Submitted_____ **Date Needed** _____

I. DATA REQUEST FORM

Health Care Excel
Indiana Medical Policy and Review Services
Data Request Form

Topic _____ Requestor _____
Date Submitted _____ Date Needed _____

1. What question is this data designed to answer?

2. What timeframe do you wish the data to cover?
   - ☐ State Fiscal Year ☐ Federal Fiscal Year
   - ☐ Calendar Year ☐ Quarter
   - ☐ Specify period of time and dates _____

3. Is the claim type relevant? ☐ Yes ☐ No
   If yes, what type? Check all that apply.
   - ☐ Dental ☐ Physician (CMS-1500) (Crossover A) (Crossover B)
   - ☐ UB92 (hospital, home health, clinic) ☐ Pharmacy (regular and compound)

4. What status of claims is needed? Check all that apply.
   - ☐ Paid claims ☐ Denied Claims ☐ All Claims

5. Should Adjustments be considered? ☐ Yes ☐ No
   Are there any special considerations? ☐ Yes ☐ No
   If yes, please explain?

6. Are any comparisons needed between subsets of the data? If so, please specify.

7. Specify all qualifiers? Check all that apply and describe each.
   - ☐ Provider Number _____
   - ☐ Provider Specialty _____
   - ☐ Certain Program _____
   - ☐ Certain Diagnosis Codes _____
   - ☐ Certain Procedures _____
   - ☐ Procedure Codes _____
   - ☐ Procedure Modifiers _____
   - ☐ Aid Category _____
   - ☐ Age Bracket _____
   - ☐ Sex _____

I. DATA REQUEST FORM (continued)

☐ Claim Number _____
☐ RID (Member) Number _____
☐ Paid Amounts _____
☐ Use Paid Dates
☐ Use Dates of Service
☐ Billing Providers only ☐ Rendering Providers only ☐ Both

8. Are any particular groupings of information to be considered?

9. What type of sort options do you want applied?

10. Is there any other important information to consider?

11. What do you want the report to look like?

12. How will this report be used? _____

13. Whom may I contact with questions? _____
Applicable phone number: _____

Application for Data _____ Query or Script Name _____

Application for Analysis _____ Final Output Name _____

DIRECTIONS FOR COMPLETING THE DATA REQUEST FORM

You must complete a form for each data request. You may attach additional pages of explanation if needed.

1. What question is this data designed to answer? What is the purpose for this data request?

2. What timeframe do you wish the data to cover? State Fiscal, Federal Fiscal, Calendar year, Quarter?

3. Is the claim type relevant? There could be in some instances where claim type does not matter. For example, if one wants information on prior authorizations, then claim type would not matter. Since queries run mainly on claim information then most requests will need a specific claim type.

4. What status of claims is needed? Paid, Denied, or All Claims. One might want only paid claims, or just denied claims, or both. Decide what corresponds to your situation.

5. How about adjustments? For some instances, one might be counting number of paid or denied claims. In this case, adjustments will have no effect on the numbers. Otherwise if you feel adjustments should be considered, please specify.

6. Are there any special considerations? For instance, are you going to compare one fiscal year's claims to a prior year's claims, so that additional years of data are needed?

7. Are any comparisons needed between subsets of the data? If so, please specify. Decide what corresponds to your situation.

8. Are there any additional qualifiers? This will be the center of the search. Please choose the applicable qualifiers and provide a description of each. Choose all that apply for your query.

9. Are any particular groupings of information to be considered? Age, gender, fiscal timeframes, program specific,.etc.

10. What type of sort options? For example; by RID number (unique recipients), by claim number, by procedure code, by diagnosis code, by age, by county, by prior authorization number, dollar amounts, etc.

11. Any other important information to consider? This is a good place to put any type of information that might be helpful in getting the data that you are requesting. Please give as much detail as possible.

12. What do I want my report to look like? This is where you would specify if you want claim number in the first column, then RID, then diagnosis, etc.

DIRECTIONS FOR COMPLETING THE DATA REQUEST FORM (continued)

13. Report use. It is always helpful to know how the report will be used, what goal you are trying to achieve, what you are trying to prove, etc.

14. Contact person. The Medical Policy department Statistician will need the name and telephone number of a person who can answer questions about the query to ensure queries, summaries, and reports meet the requestor's needs and intended use.

15. Report name. Please give the name the requestor wishes to be shown on any report produced. This will help clarify to what project or inquiry the report is related.

J. DOCUMENT TRANSMITTAL FORM

NOTE: The italicized roles listed below the Owner are additional participants in this step of the process.

K. REQUEST FOR INFORMATION-SURVEY FORM

Health Care Excel
Indiana Medical Policy and Review Services
Request for Information - Survey

Date: _____

To: _____

Attention: _____

Indiana Medicaid is currently compiling research on _____.
Your assistance in answering the few questions below would be appreciated. Information from surrounding states is of great importance in completing this project. Thank you for your assistance and cooperation.

1. In your state, does Medicaid currently provide coverage for _____?
   ☐ Yes ☐ No

2. If "no" to question 1, have you had inquiries regarding _____?
   ☐ Yes ☐ No

3. If "yes" to question 1, what are the coverage criteria for _____?
   What are the limitations/restrictions?

   Is prior authorization required? ☐ Yes ☐ No

4. What code is used for this service/product? _____

5. What pricing do you use for the service/product? _____

6. What is the total Medicaid member population in your state? _____

7. What is the Medicaid member population for this service? _____

8. Please list any additional comments.

   _____

   _____

   _____

Thank you for taking the time to respond to this inquiry. If we can be of assistance to you, please call Health Care Excel Medical Policy Department at 317-347-4500, Monday through Friday, 8:00 a.m. – 5:00 p.m., or fax us at 317-347-4573.

Date of response: _____
Name of responder: _____ Phone Number: _____

INSTRUCTIONS FOR COMPLETING REQUEST FOR INFORMATION-SURVEY FORM

1. Date the request was made

2. Individual, company, or State Medicaid name

3. Department or individual request is directed to

4. Central issue of request should be entered on lines 1, 2, and 3.

A cover letter should be written, when appropriate to explain details of the research being done and any needed information in addition to that detailed on the Request Form.

L. REQUEST FOR IHCP COVERAGE OF DME TECHNOLOGY-FORM AND LETTER

Date

Name and Address

RE: PRODUCT OR SERVICE NAME

Dear:

Thank you for your inquiry to Health Care Excel regarding coverage of (insert product/service name) by the IHCP. To properly respond to your request, we are asking you to have the manufacturer provide additional information to assist us in conducting research on this issue. The requirements for this process are found in 405 IAC 5-1-6 (a) as follows:

> Sec. 6. (a) A provider may request consideration for coverage of any new or experimental product, service, or technology not specifically covered in this article. Such a request must be submitted by the provider to the fiscal contractor along with a detailed written statement, along with all available supporting documentation, justifying the medical necessity of such product, service, or technology.

The attached form should be used by the manufacturer to assist in providing the required information. Publications or articles must be in English and must be accessible in the United States. Citations of unpublished research are not acceptable. Please have the manufacturer submit this request to the following address.

Health Care Excel
Attn: Medical Policy Specialist
2629 Waterfront Parkway East Drive, Suite 200
Indianapolis, IN 46214

If you have additional questions, please contact me at (317) 347-4500, extension xxx.

Sincerely,

Name
Medical Policy Specialist

L. REQUEST FOR IHCP COVERAGE OF DME TECHNOLOGY-FORM AND LETTER (Continued)

General requirements

This is a list of material necessary for Indiana Health Coverage Programs (IHCP) to review services or technology. Each item that is to be reviewed must be submitted on a separate request form unless the items are very closely related (i.e. same item with multiple uses or accessories/supplies for the primary item submitted). Please submit requests to the following address.

Health Care Excel
Attn: Medical Policy Department
2629 Waterfront Parkway East Drive, Suite 200
Indianapolis, Indiana 46214

1. Provide the date the item was available on the U.S. market.

2. Is the item subject to FDA regulation? If so, send documentation of the FDA's current classification and categorization of the item. Minimum requirements include a copy of form FDA-2892 and either forms FDA-2891 or FDA-2891a. If the item does not clearly meet the FDA definitions for the classification specified by the manufacturer for the device, the manufacturer may be required to submit a 513G to the FDA requesting assistance in classifying the device (a 510K application response will also meet this requirement). Proof of FDA approval to market (510K) will be required for class III and certain class II devices. If not, indicate why.

3. Indicate whether the item is subject to regulation by any other entity.

4. List the HCPCS code you feel best meets the description of your product. Was this HCPCS code assigned by CMS to this specific device(s), or did the requestor, based on the nature of the item, make this determination?

If no current HCPCS code adequately describes the item, has a request been submitted to HCFA for the assignment of a Level II HCPCS code for this item? Please detail outcome of request or why no request was submitted, as applicable. If no current HCPCS code is identified as appropriate, list all related/similar codes and details why each is considered to be inappropriate.

L. REQUEST FOR IHCP COVERAGE OF DME TECHNOLOGY-FORM AND LETTER (Continued)

5. Has a Coding Verification Review by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) been requested? If so, please include the outcome of that assessment. If not, please indicate why.

6. List all Universal Product Codes (UPC) or Universal product Numbers (UPN) for each product to be reviewed, if applicable.

7. List the wholesale cost (i.e., actual cost paid net all discounts, rebates, and incentives in cash or in-kind; best and latest information available that provides evidence of the actual cost for a specific item) and the suggested retail cost for purchase of each item to be reviewed.

8. List the daily/monthly/weekly/yearly suggested rental charges for item, if applicable.

9. List all components, accessories and services included in the base price.

10. Include color pictures of the item and current marketing literature (only originals, no photocopies). Examples of appropriate submissions include descriptive booklets or brochures, package inserts, or copies of published peer-review articles on the item (minimum of two).

11. Indicate whether you are the manufacturer, a distributor or a supplier.

12. List any other manufacturer or supplier of similar items.

13. Identify the difference between this item and that of competitors.

14. Indicate whether or not the item has been subject to an assessment by any other agency or recognized medical body and provide a copy of the results of the assessment(s). This includes all other state Medicaid programs and/or commercial insurance carriers. Additionally, list all payer sources that have reimbursed for this item to date.

L. REQUEST FOR IHCP COVERAGE OF DME TECHNOLOGY-FORM AND LETTER (Continued)

Please include the information listed below for the category that best describes your product:

Durable Medical Equipment and Supplies

1. Provide an exact description of the item. Include all component parts and/or accessories.

2. Provide a description of how this equipment operates and functions.

3. Provide a list of all the supplies necessary for the use and operation of the equipment.

4. List the indications for use of the equipment.

5. Send Operations and Patient Instruction Manuals.

6. Send warranty information for the equipment and component parts.

7. Provide the recommended duration of use for all supplies associated with the equipment.

8. Include results of clinical studies that have been performed using this equipment. Peer-reviewed articles are needed.

Support Surfaces/Seating Cushions

1. Provide a detailed description and exact dimensions of the product. This should include the height, depth, and width of all components and the completed product.

L. REQUEST FOR IHCP COVERAGE OF DME TECHNOLOGY-FORM AND LETTER (Continued)

2. Include a description of how the product functions and the indications for use of this product.

3. Provide pictures of the product without a cover.

4. Send warranty information for all parts and accessories of the product.

5. Include Users manuals for the product.

6. All requests for Medicare-determined Group 2 support surfaces must include documentation to substantiate that the product is effective for treatment of conditions described in the coverage criteria.

Orthotics and Prosthetics

1. Provide an exact description, including how it is made and the materials from which each component is made.

2. Include a description of where on the body the device or item is to be worn or used.

3. List the indications for use of the item and how the patient is taught to apply.

4. For products with several components, include a full picture of each component unobstructed and an explanation of how it is attached to the product.

5. Provide a detailed description of the amount of effort required by the orthotist/prosthetist for molding/fitting of this product. Indicate if this is included in the list price for the service. If not, indicate how this may be reimbursed.

L. REQUEST FOR IHCP COVERAGE OF DME TECHNOLOGY-FORM AND LETTER (Continued)

Details of Requestor

Request Submitted by:

Name: _____

Name of Organization: _____

Complete mailing address: _____

_____

Telephone number: _____

Fax number: _____

E-mail address: _____

Please note if the manufacturer of the item identified in this request is not identified above, please also provide the name, address, and telephone number of the manufacturer.

M. REQUEST FOR POLICY PROJECT RESEARCH

Health Care Excel
Indiana Medical Policy and Review Services
Request for Medical Policy Project Research

Potential Project Name: _____

Date: _____ **Referred By:** _____

Please complete as much of the following information as possible and forward to the Medical Policy Director for consideration. At a minimum, you must supply a complete description of the issue and goal.

ISSUE: (Give a concise but comprehensive description of the issue, including the history of the issue (how/where/why the issue arose).

GOAL: (What do you want to be accomplished?)

To be completed by Medical Policy:

ASSIGNED TO: _____

TASKS TO BE COMPLETED: (List the tasks that you believe will need to be completed to make clear, concise, recommendations to OMPP.)

_____

_____

_____

_____

VI. QUALITY MANAGEMENT

The primary objective of HCE will be to administer the IMPRS contract in a manner that promotes the timely delivery of appropriate services, supports the objectives and guiding principles of the IHCP, and promotes efficiency and effectiveness throughout the program. We will educate and support the staff to achieve these objectives. The Quality Management Plan delineates the components of performance and standards and is a companion plan to the MP Operations Procedures.

The foundation for our continuous quality improvement efforts will be a high level of sensitivity and responsiveness to the needs of individuals and organizations involved in, and associated with, the IHCP. Our strategy will involve the identification of the types of information that are needed, who needs it, how to gather, analyze, and present the information, how to evaluate the effectiveness of the information and our services, and last, but not least, how to improve in the provision of information and delivery of services to our customers.

Each employee will serve multiple customers. Employees have the responsibility and the accountability to know their customers, understand changing expectations, and consistently perform to meet or exceed those expectations. Employees are more capable of pleasing the external customers when they work well together as customers of each other through planning, communicating, and producing quality, timely work products and services. An effective project management system will be established and maintained with these desired features.

Quality and Reliability: ensuring conformance to the contract and its performance standards.

Timeliness: ensuring that each deliverable is provided within the prescribed timeframe.

Efficiency: ensuring that tasks are completed within the approved cost parameters.

Although individual department performance rests primarily with the department Director, they also attach to other departments and individuals to achieve total contract compliance and exemplary performance. Collaborative interdependency is critical to the successful achievement of the State's program objectives. The management will be held accountable for contract performance, as evidenced through measurements of the quality, timeliness, and production of contract services. Management will impart knowledge to their coworkers and subordinates through formal training programs, one-on-one consultations, and feedback from the performance monitoring system.

A. Education of MP Staff

MP staff will receive education as established by the Quality Management Plan. Education will be provided through several forums. These will include formal programs, information conveyed in staff meetings, and routing and posting of written information. Knowledge will be assessed through the use of pre- and post-training knowledge assessments return demonstrations, and observation of daily work, among others.

Initial generalized training will consist of elements for which a basic understanding is required for successful management of the IMPRS contract. New employee general training elements have been stated below.

- Business Risk Management
- Communications and Central Points of Contact
- Confidentiality Plan
- Customer service attitude
- Documentation protocols and standards
- Fraud Prevention
- HCE policies and procedures
- HIPAA Security and Privacy Requirements
- ISO Standards
- Operation of equipment
- Overview of IHCP
- Overview of the MP contract
- Overview of the MP department
- Overview of the PA department
- Overview of the SUR department
- Partners and other program entities
- Principles of continuous quality improvement
- Program integrity
- Provider and member constituency groups
- Quality management and performance standards
- Responsibilities and duties of other contractors
- Safety
- Security
- State Ethics Training
- Use of hardware and software

B. Plan for Remedial Education

Every effort will be made to assist employees to succeed. Remedial education will be available for employees who are at risk of failure. Knowledge assessments will be administered to establish indicators of adequate understanding to conduct duties. A minimum score of ninety-five percent (95%) will be required to continue to

perform without remedial education. Remedial education will be individualized to best match the person's needs. In the event that a significant department performance deficiency has been identified that is beyond the acceptable range of performance and has not been able to be resolved, a performance improvement plan (PIP) will be developed and implemented. The PD will request that the MPD develop and submit a PIP. The process for performance improvement has been delineated in the Quality Management Plan.

C. Education for Consultants and Advisory Panels

Physicians and other consultants will receive education appropriate to their services on behalf of the MP department. Typically, an explanation of the medical policy issue and the reason for the involvement of the consultant or association should be sufficient to convey the purpose for the services. The explanation usually will be accompanied by written materials.

Independent consultants and reviewers will be subject to standards of professional performance and privacy standards. The MD will have an important role in the education, monitoring, and feedback associated with consultants. The establishment and support of productive and meaningful relationships between the MP contractor and the provider community is an essential ingredient to appropriate program management. Support of association education will be conducted through a variety of venues, including participation in provider meetings and training, contribution to bulletins and other published written material, responsive and timely letters to inquiries and complaints, and the use of credible specialists to support the work of the development and maintenance of medical policies that reflect acceptable standards of care.

D. Performance Measurement

It is important that each person employed by HCE possess a personal and professional interest in ensuring that the administration of the MP contract is successful, innovative and rewarding. It is imperative that each employee understands and respects the program requirements and feels an obligation to assist in the improvement of processes used to fulfill responsibilities. HCE is receptive to suggestions for the enhancement of current functions, the betterment of written policies and criteria, and the upgrading of the overall effectiveness of the IMPRS operations.

To ensure that responsibilities are met efficiently and timely, the internal Quality Management Plan will provide the framework to monitor internal process performance and provide information to:

- support and foster continuous quality improvement;
- develop and implement processes that ensure all activities run efficiently, comply with the contract, and are consistent with IHCP goals and objectives;
- maintain activities within a permissible range of deviation;
- improve the reliability, accuracy, consistency, and timeliness of data and information; and
- promote the IHCP through the provision of credible services.

For each business function, the monitoring plan establishes a control process, which meets the following objectives.

- Identifies what is subject to control and the elements measured through monitoring the organization's and individual's performance; monitoring the specific inputs, processes, and/or outcomes; and recognizing the most vital elements that account for most of the variations in performance.
- Sets the controls standards (including tolerance limits) through the use of measures that permit a determination if performance is acceptable, and if the quality and quantity of the output are adequate to support organizational and program objectives.
- Identifies the information to be collected and how performance will be measured (e.g., what is being done and what should be done).
- Determines the reason for deviation through an assessment of the causes of any deviations from the standards.
- Provides appropriate and timely feedback on performance.
- Identifies and monitors improvement actions through decisions on the best course of action for eliminating deviations or for exceeding current performance.

The department Directors will evaluate several elements. Performance indicators will be based on measurements associated with numerical ratings (volume, timeliness, number of complaints about performance, etc.), as well as feedback from more subjective factors (opinions about performance from surveys, State officials, other contractors and partners, providers, members, and other sources). Monthly department performance reports will be submitted to the PD and other members of the Operations Assessment Committee. For each standard, the variance (exception) will be accompanied by comments explaining the cause and action, if any, needed to address the variance.

Several key indicators of performance associated with the MP department, and expanded in the Quality Management Plan, have been listed below.

- Staffing levels and types of staff
- Staff competency
- Avoidance of backlogs
- Adequacy and accuracy of medical policy documents
- Timely and accurate reports to the State
- Responsiveness within three days to State requests
- Adequacy of coordination responsibilities
- Achievements associated with the Annual Business Plan
- Management of the MP Committee
- Adequacy of medical criteria
- Accuracy of entry in Indiana*AIM*
- Availability to participate in meetings

The PD has been delegated the responsibility to create and maintain the Quality Management Plan, support internal monitoring and improvement, and facilitate education programs and knowledge assessments. The PD is a member of the Operations Assessment Committee.

E. Operations Assessment Committee

The organization of our staff enhances communications between and among the various departments. To address each business function, we have created three operations departments. However, there are various techniques to facilitate movement of information and export expertise across all departments. One technique is the Operations Assessment Committee (OAC).

The OAC is formally comprised of the PD, MD, and the Directors for MP, PA, and SUR. Other employees may participate, as appropriate to the agenda items.

The OAC focuses on continuous quality improvement of all contract events and deliverables. The committee is charged with establishing meaningful contract performance measures, instituting and maintaining effective contract monitoring processes, collecting performance data, using performance data to institute action, and evaluating the adequacy of total contract fulfillment.

E. Medical Policy Quarterly Customer Satisfaction Survey

Following the last business day of each calendar quarter, the Medical Policy Department will measure customer satisfaction with the information, guidance, clarifications, and responses the Department has provided to stakeholders over the most recently-completed quarter. The following procedures are to be used to conduct the customer satisfaction survey, tabulate results, and disseminate the information to the Indiana Health Coverage Programs and internally.

1. The Medical Policy Statistician extracts from the Master Log, the following information for closed inquiries that have been addressed by the Department during the most recent, closed, quarter:

    - Source (= Provider)
    - Source Name
    - Source Phone Number
    - Tracking #
    - Service Category
    - Assigned to
    - Status (= Closed)
    - Finish Date (Response Date) (between _X-date_ and X-date__)
    - Inquiry Type

2. The Medical Policy Statistician creates a MS Excel spreadsheet containing the information listed in procedure #1 above.

3. The Medical Policy Statistician randomly selects 10 unique inquiries per Medical Policy Specialist, based on tracking numbers. The selected records are transferred to MS Excel.

4. The Medical Policy Statistician forwards to the Medical Policy Secretary the MS Excel spreadsheet referenced in #3 above.

5. The Medical Policy Secretary utilizes the MS Excel spreadsheet and the appropriate form letter (Attachment 1) to mail merge the names and addresses of those to receive the survey. The form letter included herein as Attachment 1 should be used for the mail merge and placed on HCE letterhead. The letter should request that the survey be returned within 3 to 4 weeks. The Medical

Policy Secretary will consult the Medical Policy Director for a specific due date to record on the letters.

6. The Medical Policy Secretary obtains the signature of the Medical Policy Director for each letter (Attachment 1) to be mailed.

7. The Medical Policy Secretary locates the surveys to be mailed (Attachment 2). The surveys, at a minimum, are comprised of the following questions and information:

Survey Questions	Not Satisfied 1	Somewhat Satisfied 5	Satisfied 10
1. How satisfied were you with the speed of response to your inquiry?			
2. How satisfied were you with the accuracy of the information provided?			
3. Health Care Excel staff was professional courteous and responsive?			
4. The information provided was clear, concise, and thorough in addressing my inquiry?			
5. The information received assisted me in better understanding Medicaid program policies that impact my practice?			
6. In your opinion how can Health Care Excel make its Medical Policy department more responsive and helpful to Indiana Health Coverage programs providers?			
7. Please share any additional information or comments below:			

8. The Medical Policy Secretary records a unique number (starting from "1") at the bottom right hand corner of each survey. The Medical Policy Secretary also records this unique number in the MS Excel spreadsheet next to the appropriate corresponding record for the stakeholder who will receive each survey.

9. The Medical Policy Secretary stuffs the following into a large envelope for each stakeholder who will participate in the satisfaction survey process.

   a. Cover Letter/ Instructions
   b. The Survey to Be Completed
   c. A Self-Addressed Stamped Envelope

10. The Medical Policy Secretary presents to the Medical Policy Director, a copy of a completed packet. The Medical Policy Director will review the packet for formatting and content. Upon approval, the Medical Policy Secretary will mail the packets to the appropriate individuals.

11. When completed packets are received, the Medical Policy Secretary will:

    a. Open each envelope
    b. Staple each envelope to the corresponding completed survey
    c. Record and tabulate the answers provided by each stakeholder (See Attachment 3)
    d. Provide a summary document to the Medical Policy Director (Attachment

12. The Medical Policy Director will share the results with the IMPRS Program Manager and with the IHCP.

Medical Policy Quarterly Customer Satisfaction Survey (continued)
Attachment 1: Cover Letter for Satisfaction Surveys

Provider
Contact
Address
Address1
City, State ZIP

Date

Dear Medicaid Service Provider:

The Office of Medicaid Policy and Planning, the entity that administers the Indiana Health Coverage Programs (IHCP) is assessing provider satisfaction with the medical policy (MP) function of the Medicaid program. Specifically, we are surveying providers to understand their thoughts, concerns, and impressions of the medical policy function within the IHCP. Medical Policy is the area within the IHCP that reviews, revises, drafts, and evaluates medical policies for the Indiana Medicaid program. MP also provides consistent guidelines and policies for IHCP programs. Our records indicate that you have contacted the IHCP medical policy contractor, Health Care Excel, at least once over the past quarter. We request your assistance by completing the attached survey.

The survey is comprised of five short multiple choice questions and includes two open-ended questions where you may record whatever information you would like to share with the IHCP. Please complete the survey, place it in the attached self-addressed-stamped-envelope, and place it in a mailbox. We thank you in advance for your time and attention to this very important matter.

If you have questions, comments, or concerns about the survey, we would be happy to address them, if you phone us at 317-347-4500 or write us at along@hce.org.

Sincerely,

Albert J. Long, III, M.P.A.
Director, Medical Policy

Medical Policy Quarterly Customer Satisfaction Survey (continued)
Attachment 2: Medical Policy Quarterly Satisfaction Survey

To assess and identify opportunities to improve customer service and quality, Health Care Excel, the contractor that assists the Indiana Health Coverage Programs (IHCP) and the Office of Medicaid Policy and Planning (OMPP) with medical policy issues is surveying Medicaid providers who have contacted the program within the past quarter.

Please assist us by choosing the option below that best reflects your experience with our firm. Once completed, please place the completed survey in the attached postage-paid envelope and drop it in a mailbox.

1. How satisfied were you with the speed of response to your inquiry?

1	5	10
Not Satisfied	Somewhat Satisfied	Satisfied

2. How satisfied were you with the accuracy of the information provided?

1	5	10
Not Satisfied	Somewhat Satisfied	Satisfied

3. Health Care Excel staff was professional, courteous, and responsive?

1	5	10
Not Satisfied	Somewhat Satisfied	Satisfied

4. The information provided was clear, concise, and thorough in addressing my inquiry?

1	5	10
Not Satisfied	Somewhat Satisfied	Satisfied

5. The information received assisted me in better understanding Medicaid program policies that impact my practice?

1	5	10
Not Satisfied	Somewhat Satisfied	Satisfied

6. In your opinion, how can Health Care Excel make its Medical Policy department more responsive and helpful to Indiana Health Coverage programs providers?

7. Please share any additional information or comments below:

Medical Policy Quarterly Customer Satisfaction Survey (continued)
Attachment 3: Survey Results

Survey Questions	Not Satisfied 1	Somewhat Satisfied 5	Satisfied 10
How satisfied were you with the speed of response to your inquiry?			
How satisfied were you with the accuracy of the information provided?			
Health Care Excel staff was professional courteous and responsive?			
The information provided was clear, concise, and thorough in addressing my inquiry?			
The information received assisted me in better understanding Medicaid program policies that impact my practice?			

6. In your opinion how can Health Care Excel make its Medical Policy department more responsive and helpful to Indiana Health Coverage programs providers?

7. Please share any additional information or comments below:

INDEX

Page Number

INDEX

Page Number

APPENDIX A
DOCUMENTATION CHANGES

DATE OF REVISION	REVISION NUMBER	REVISED AND/OR NEW PAGES	DESCRIPTION	APPROVED
07/29/05	5	ii through iv	Changed Table of Contents to comport with revisions	
07/29/05	2	III-13	Replaced "reference file system requests (RFSRs)" with "reference change orders (RCOs)"	
07/29/05	3	III-25	Replaced "Procedures for Reference File Changes for Indiana*AIM*" with "Procedures for Reference Change Orders for Indiana*AIM"*	
07/29/05	3	III-26-III-27	Replaced "Table III-5: Reference File Changes Procedure" with Table III-5: Reference Change Order Procedure"	
07/29/05	3	III-28	Replaced "Reference File Changes Procedure Flowchart" with Reference Change Order Flowchart"	
07/29/05	1	III-29	Added "Life of a Reference Change Order Process Flow Indiana XIX"	
07/29/05	1	III-30	Added "Reference Change Order (RCO) Form"	
07/29/05	4	IV-7	Replaced "reference file system requests" with "reference change orders"	
07/29/05	4	IV-7	Replaced "(RFSRs)" with "(RCOs)"	
07/29/05	4	IV-7	Deleted "Section 4.0 Inquiries Received from the Surveillance and Utilization Review department"	
07/29/05	4	IV-7	Deleted "Section 5.0 Status of New Code Applications from the Centers for Medicare and Medicaid Services (CMS)"	
07/29/05	2	VI-9	Updated Medical Policy Quarterly Customer Satisfaction Survey Cover Letter	
04/30/05	5	Index 1–Index 2	Updated Index to comport with revisions	